COMMUNITY RESOURCE ASSESSMENT: 2002

VIRGINIA PREVENTION NEEDS ASSESSMENT:
ALCOHOL AND OTHER DRUGS

Table of Contents

List of Exhibits

EXECUTIVE SUMMARY

INTRODUCTION

This report presents the findings of the Virginia Community Resource Assessment. The Community Resource Assessment was conducted as part of a national effort funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP). The purpose of the Community Resource Assessment was to collect information on available prevention resources that target risk factors and problem behaviors related to alcohol, tobacco, and other drug (ATOD) use.

In direct response to the need for effective ATOD prevention programming, the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (VDMHMRSAS) through a contract with the Center for Substance Abuse Prevention (CSAP) conducted a statewide prevention needs assessment. The Virginia Statewide Prevention Needs Assessment involves three studies: (1) a Community Youth Survey, (2) a Social Indicator Study, and (3) a Community Resource Assessment, which collected information on available prevention resources across the Commonwealth of Virginia.

Prevention needs assessment data is essential to planning across all levels of the prevention system, from individual program planning to State-level strategy development. The main goal of the CSAP Prevention Needs Assessment is to provide prevention planners with current and accurate information that may be used to improve the match between service needs and available community resources. Additionally, the results should be utilized by local and State prevention agencies to ensure that programs and services address identified risk factors and capitalize upon identified protective factors and resources.

BACKGROUND

The theoretical background for the Community Resource Assessment is based on the Risk and Protective Factor Framework endorsed by CSAP and is widely accepted in the prevention field. The Risk and Protective Factor Framework is a systematic, theoretically grounded approach for the development of community-based prevention programming. Risk factors are variables that increase the likelihood of ATOD use, while protective factors are variables that decrease the likelihood of ATOD use or buffer the negative effects of risk factors. The major premise of the framework is that the reduction of risk factors and enhancement of protective factors will reduce the incidence of ATOD use.

The preponderance of approaches currently employed to prevent ATOD use among youth follow a basic public health problem/response approach that includes (1) defining the problem, (2) identifying risk and protective factors, (3) identifying and implementing interventions, and (4) program evaluation.

The current Virginia Community Resource Assessment provides data that can be used to help identify and implement prevention interventions.

METHODOLOGY

Sample/Procedure

The target population for the Community Resource Assessment included prevention specialists familiar with State-, regional-, and local-level prevention resources in the Commonwealth of Virginia. The target population consisted of employees from a variety of prevention agencies, including State and local government, nonprofit, universities and colleges, and religious organizations. Two samples participated in the Community Resource Assessment: Phase I participants and Phase II participants.

Personal interviews were conducted with 38 State-level prevention administrators during the Phase I data collection. Data collected during Phase II was comprised of a total of 338 completed surveys received from local program directors.

Instruments

The data collection instruments utilized in Phase I and Phase II were based on CSAP's Core Community Resource Assessment Survey. The Community Resource Assessment Surveys were designed by a CSAP workgroup comprised of researchers and State representatives involved in the Statewide Prevention Needs Assessment process.

The Phase I interviews consisted of 122 questions divided into the following categories: prevention needs, agency/department's main goals or objectives, services provided, staff credentials/training, budget/funding, collaboration activities, data/evaluation, and barriers to service delivery. The Phase II survey was an 8-page document with 171 questions divided into the following categories: prevention needs in locality, program goals and objectives, regions served, programs/services, program intensity, population demographics, staffing/qualifications, budget, data and evaluation, and barriers to service delivery.

FINDINGS

As stated previously, the purpose of the Community Resource Assessment was to identify available prevention resources that target risk and protective factors. Findings from the Phase I and Phase II surveys will allow the Commonwealth of Virginia to address Step Three (i.e., identifying and implementing interventions) in the problem response public health approach to prevention planning. However, a number of findings from the Phase I and Phase II surveys are not relevant for this purpose. Therefore, these findings will not be discussed in the following section. Only findings that are believed to be relevant for Step Three for prevention planning will be described below.

These findings include: program/office goals and objectives; program services; budget/funding; and training and TA provided to the field. A detailed description of all survey findings may be found in the full report text.

GOALS AND OBJECTIVES

To collect information on program goals and objectives, Phase I and Phase II respondents were asked, in an open-ended question, to report their offices' main goals or objectives.

Exhibit 1 presents the Phase I findings for the reported main goals and objectives. In the Commonwealth, the most common objective was *building effective prevention programs in the field through program monitoring, training, and program evaluation* (34.2%), followed by *meeting the needs of localities, including local citizens and local programs* (18.4%), and the *prevention of ATOD use* (16%).

Exhibit 1
Program Objectives: Phase I Respondents
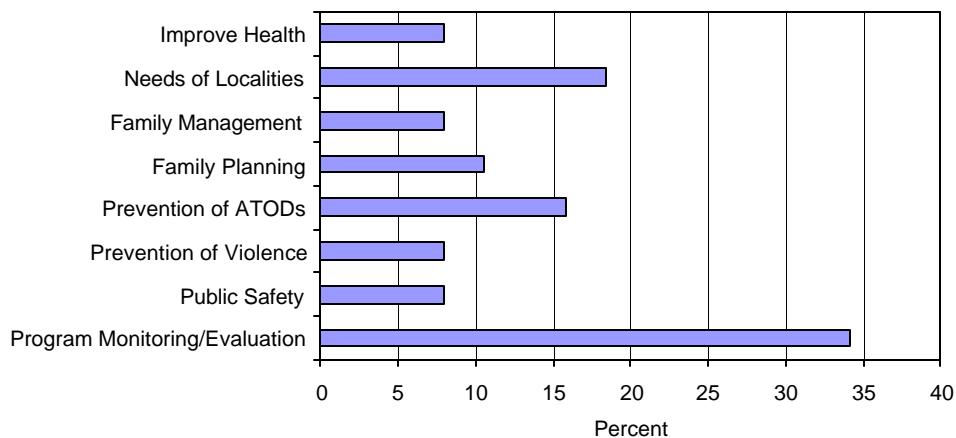
Exhibit 2 presents the Phase II findings for the Commonwealth. In the Commonwealth, the most common program focus was *life skills/social skills training* (18.9%). The second most commonly reported program focus was *family management skills* (17%). More than 15 percent of respondents reported that *providing positive alternative activities for youth* was a main program focus.

Exhibit 2. Program's Main Focus—Commonwealth: Phase II Respondents
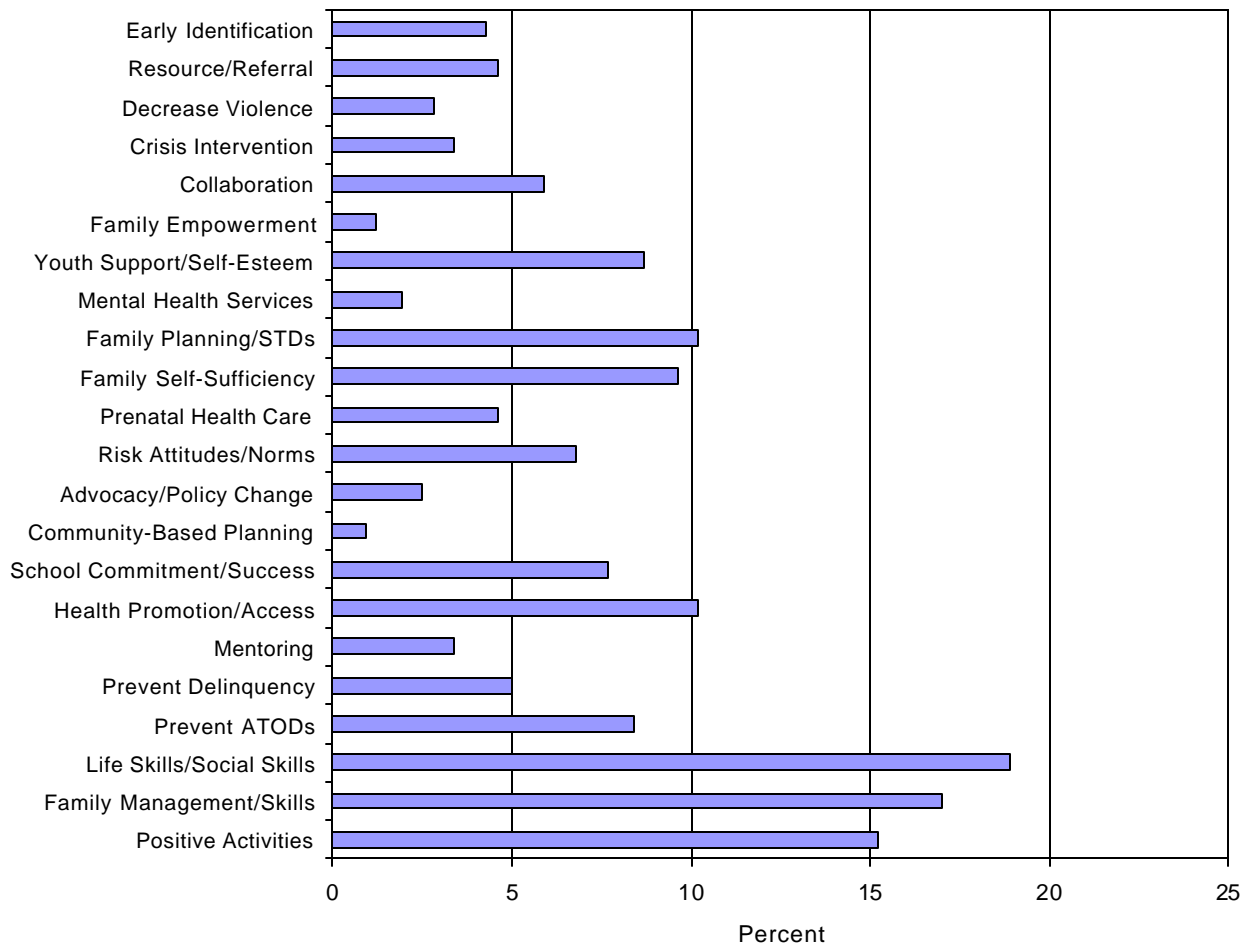
Exhibit 3 presents the Phase II findings for HPR I. The three most commonly reported foci for programs in HPR I were providing *life skills/social skills training*, *family management skills*, and *family planning/STDs*. Almost one-fourth of the respondents reported that providing *life skills/social skills training* was a main program focus. Approximately 20 percent of respondents in HPR I reported that providing *family management skills* was a major program focus. The third most commonly reported program focus was *family planning/STDs* (15.4%).

Exhibit 3. Program's Main Focus—HPR I: Phase II Respondents
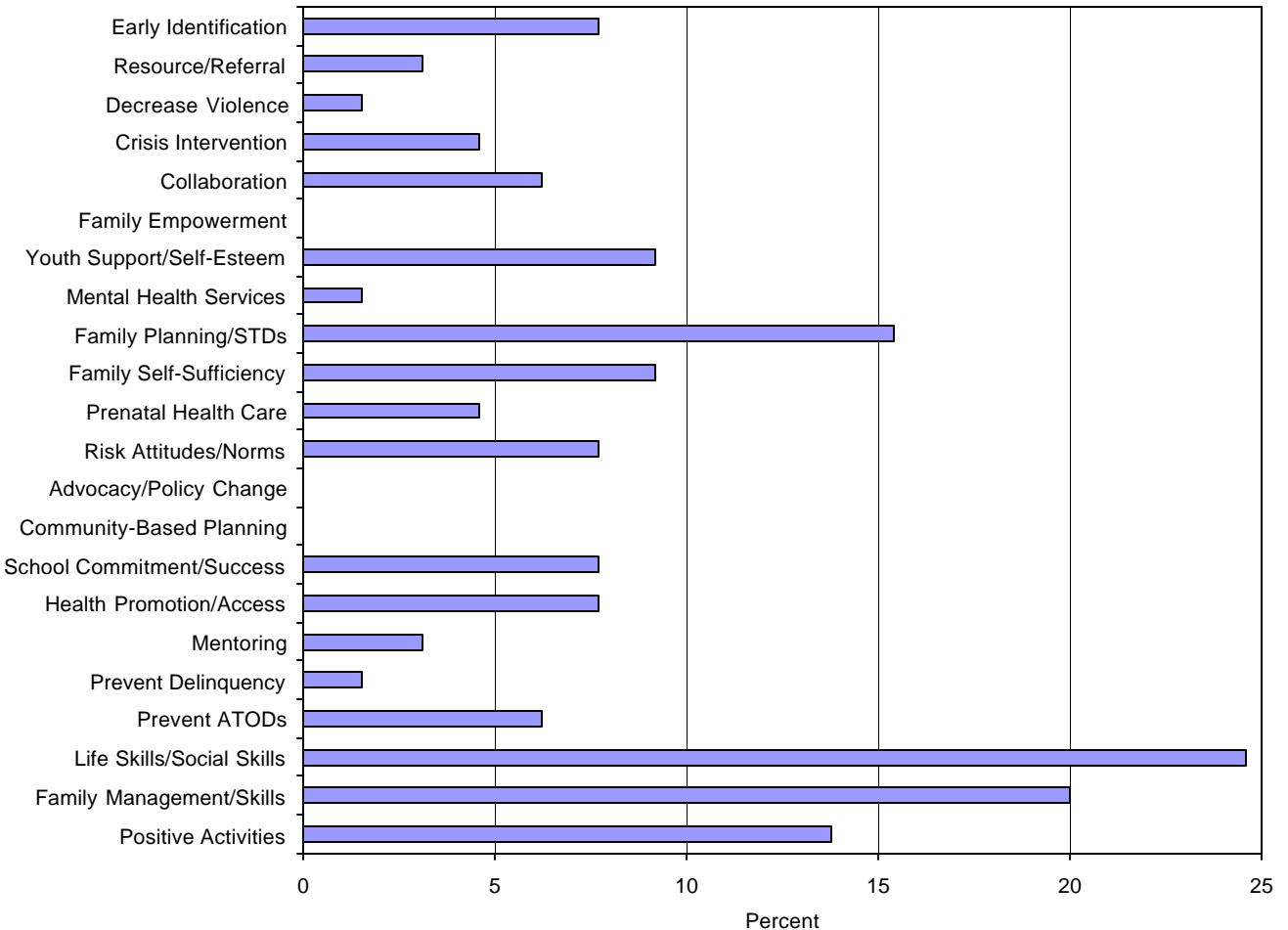
Exhibit 4 presents the findings for HPR II. The three most commonly reported program foci in HPR II were *family management skills* (19.2%), *family self-sufficiency* (16.4%), and *life skills/social skills training* (15.1%).

Exhibit 4. Program's Main Focus—HPR II: Phase II Respondents
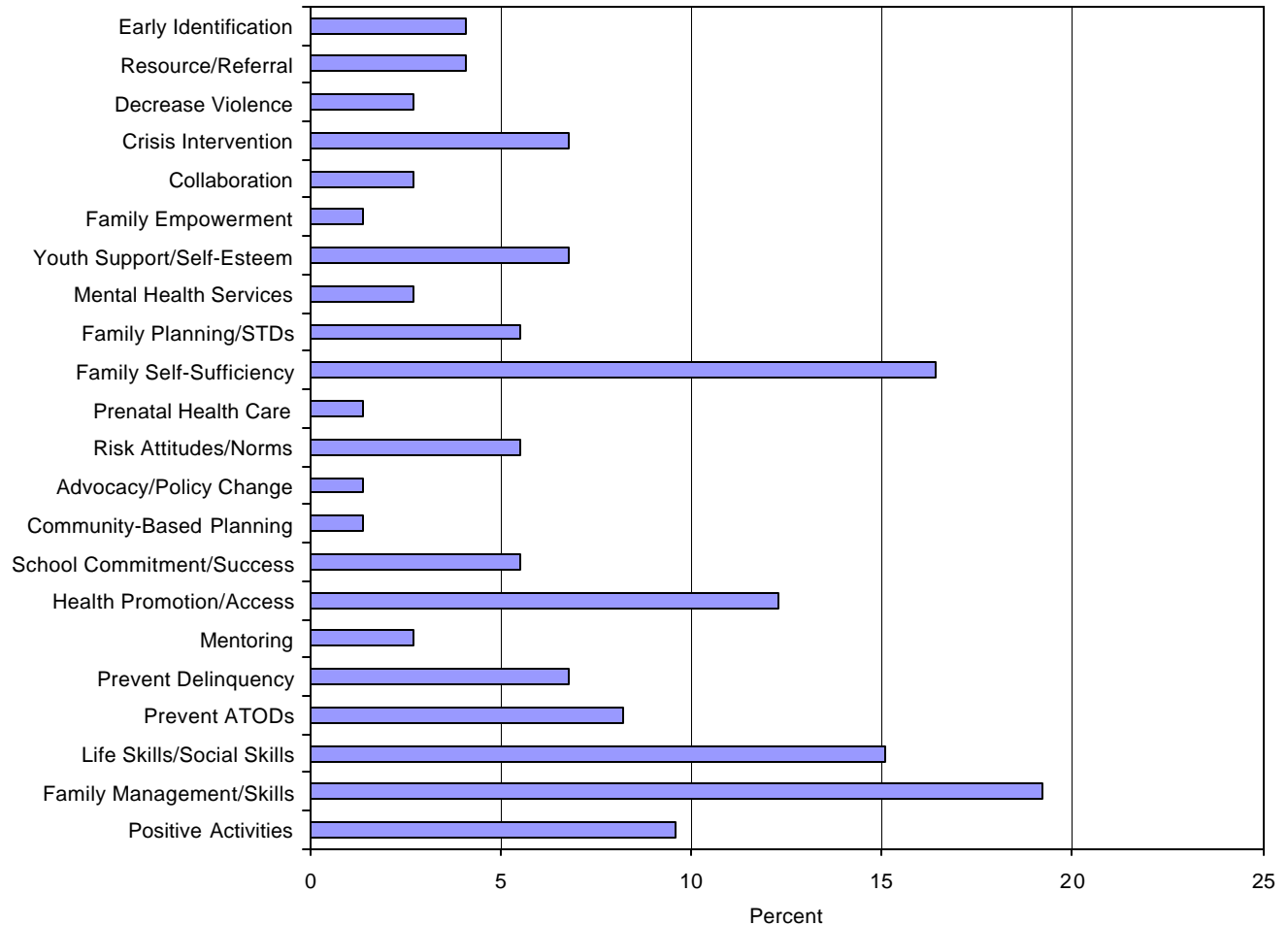
Exhibit 5 presents the Phase II findings for HPR III. The most common program focus reported by respondents in HPR III was providing *life skills/social skills training* (18.1%), followed by providing *family management skills* (16%), and increasing *positive alternative activities* (13%). Excluding the *prevention of ATOD use* (12.5%) and *providing youth support* (12.5%), all other categories were endorsed by less than 10 percent of respondents as main program foci in HPR III.

Exhibit 5
Program's Main Focus—HPR III: Phase II Respondents
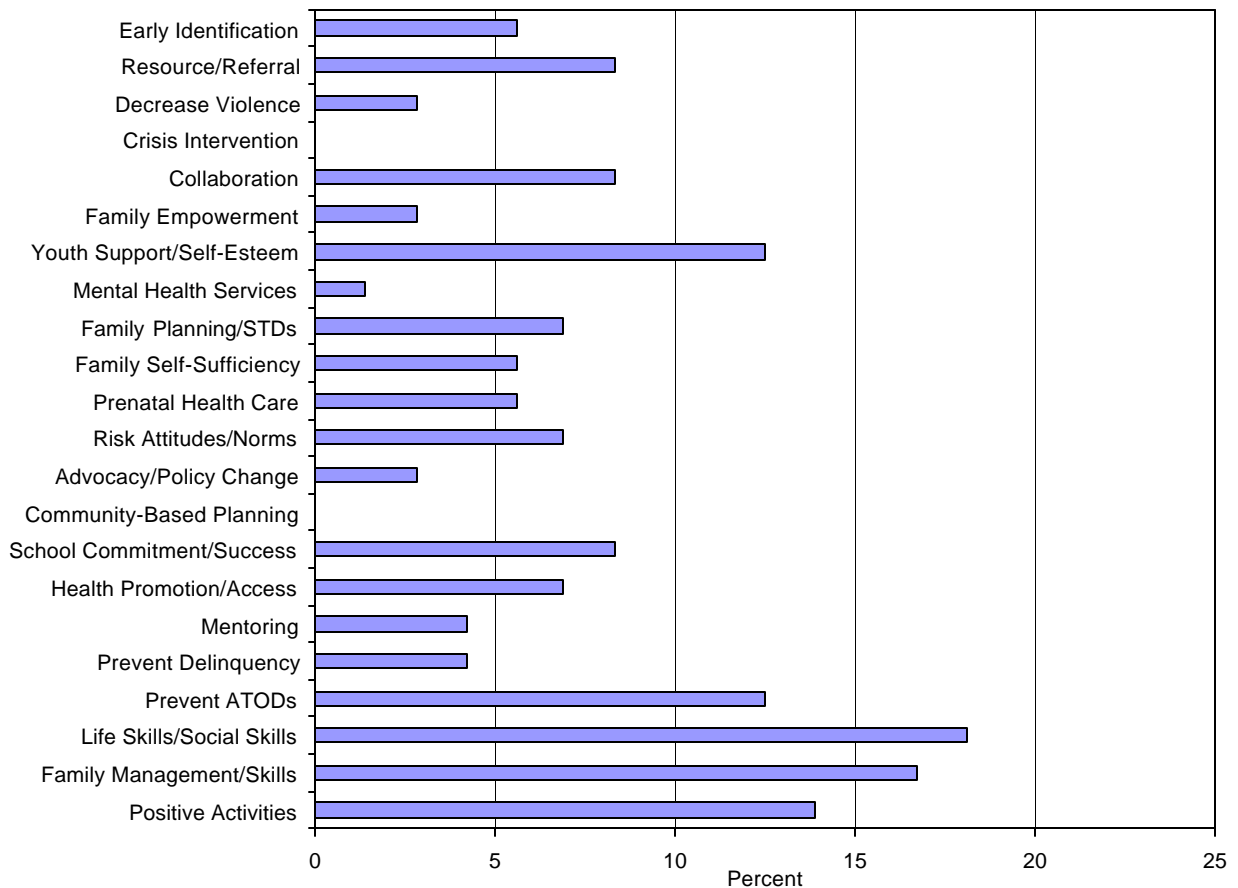
Exhibit 6 presents the Phase II findings for HPR IV. Almost one-fourth of the respondents reported that *providing positive alternative activities* was a main program focus in HPR IV. The second most commonly reported program focus was providing *life/social skills training* (18.3%). Fifteen percent of respondents reported that providing *family management skills* was a main program focus, the third most commonly reported program focus.

Exhibit 6
Program's Main Focus—HPR IV: Phase II Respondents
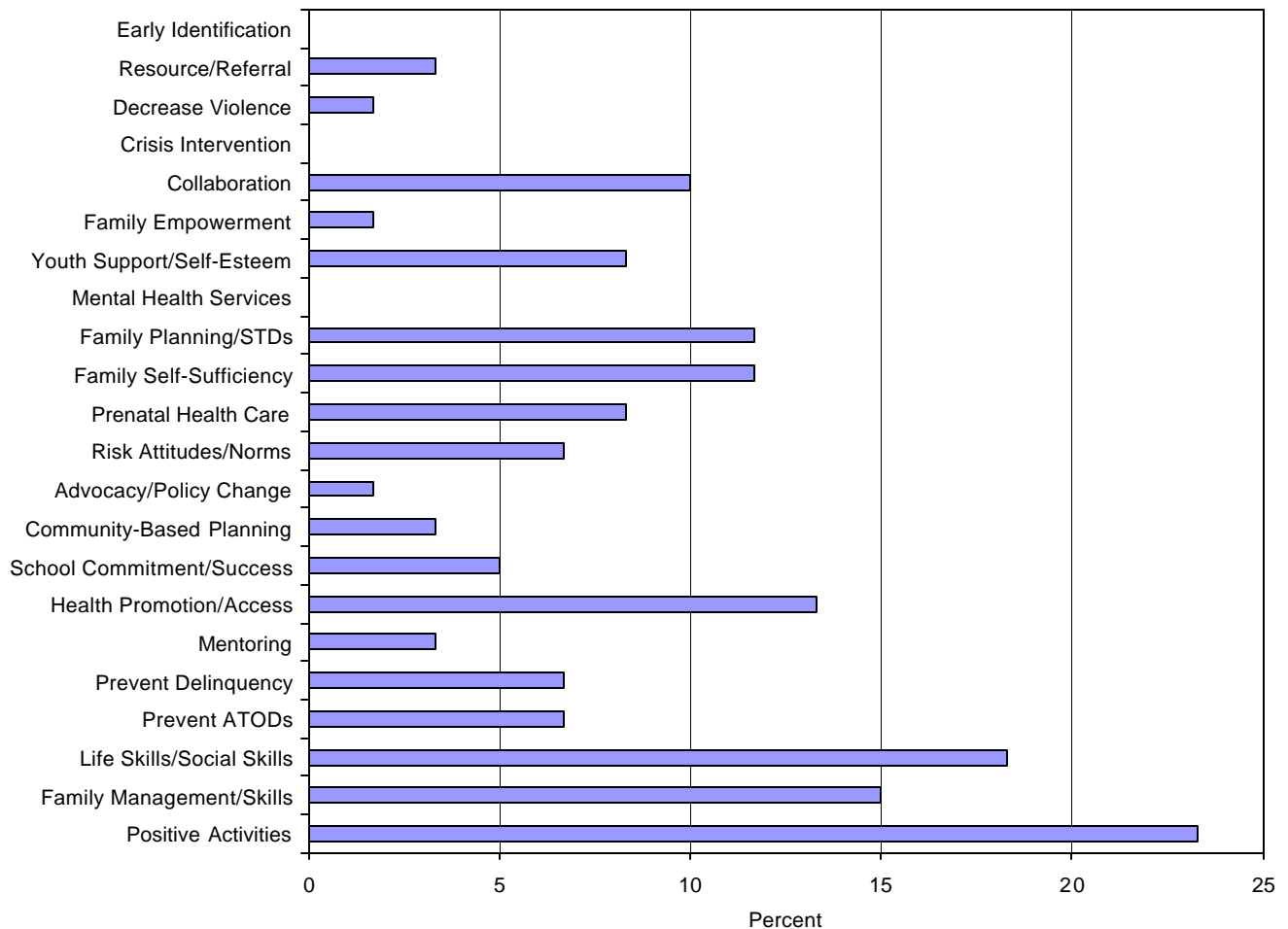
Exhibit 7 presents the Phase II findings for HPR V. Similar to the other HPRs, the most common program focus reported by HPR V respondents was providing *life/social skills training* (20%). Seventeen percent of respondents reported that providing *family management skills* was a main program focus. The third most commonly reported program focus was providing *positive alternative activities* (15.4%).

Exhibit 7
Program's Main Focus—HPR V: Phase II Respondents
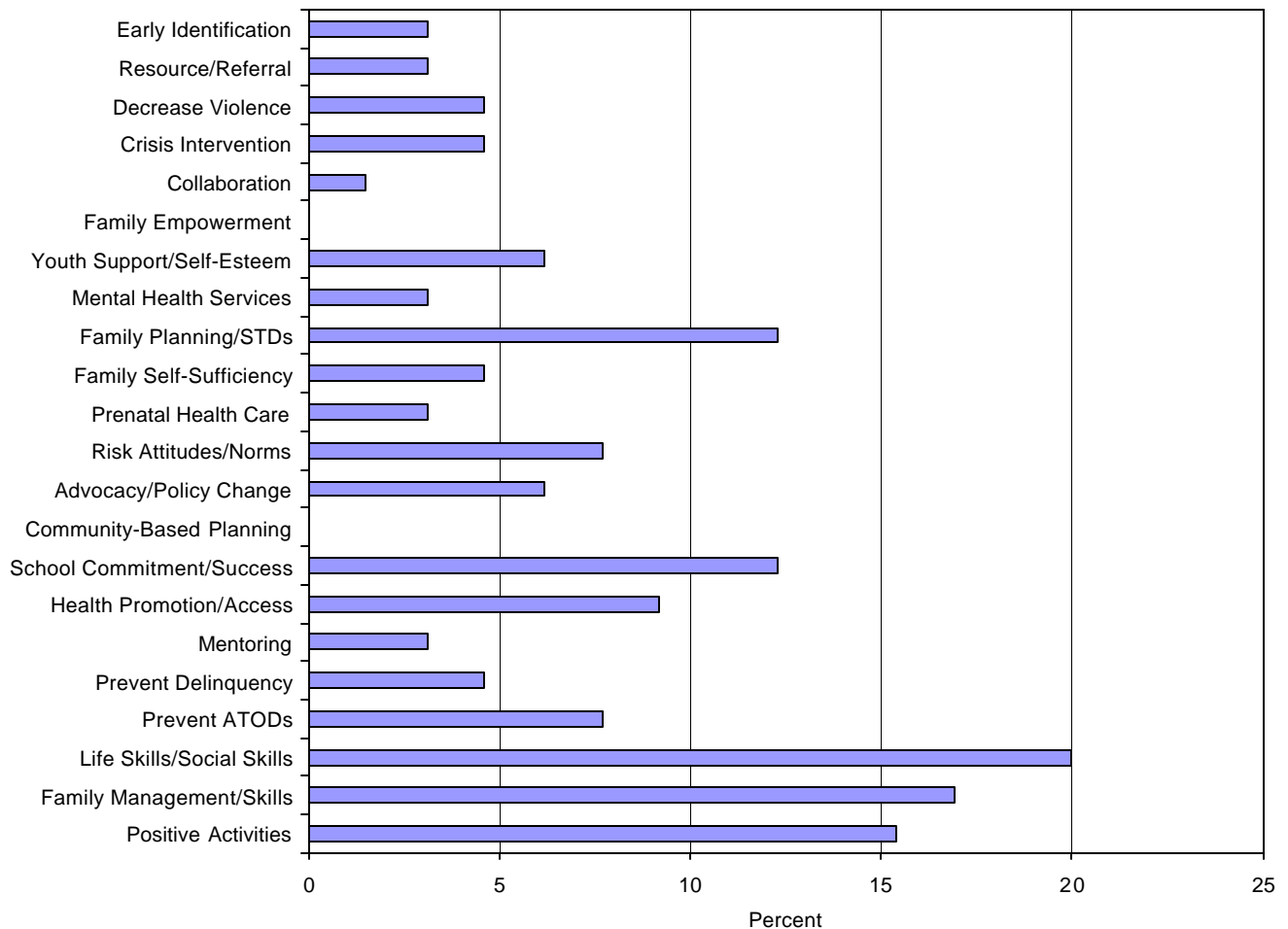
In addition, Phase II respondents were asked in a close-ended question to indicate which of a list of goals and objectives were either (1) a main program focus, (2) addressed but not a main program focus, and (3) not addressed. The goals and objectives were categorized into the four risk factor domains: peer/individual, family, school, and community.

Peer and Individual Domain

Exhibit 8 presents the Phase II findings for the Commonwealth. By far, the most common objective that was reported to be a main program focus in the individual and peer domain in the Commonwealth was the *improvement of life/social skills* (51.0%). In fact, the majority of respondents (87.1%) indicated that the improvement of social skills was at least addressed by their program. The second most commonly reported objective was *strengthening attitudes against antisocial behaviors* (35.5%), followed by *preventing antisocial behaviors* (34.4%).

Exhibit 8
Commonwealth Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
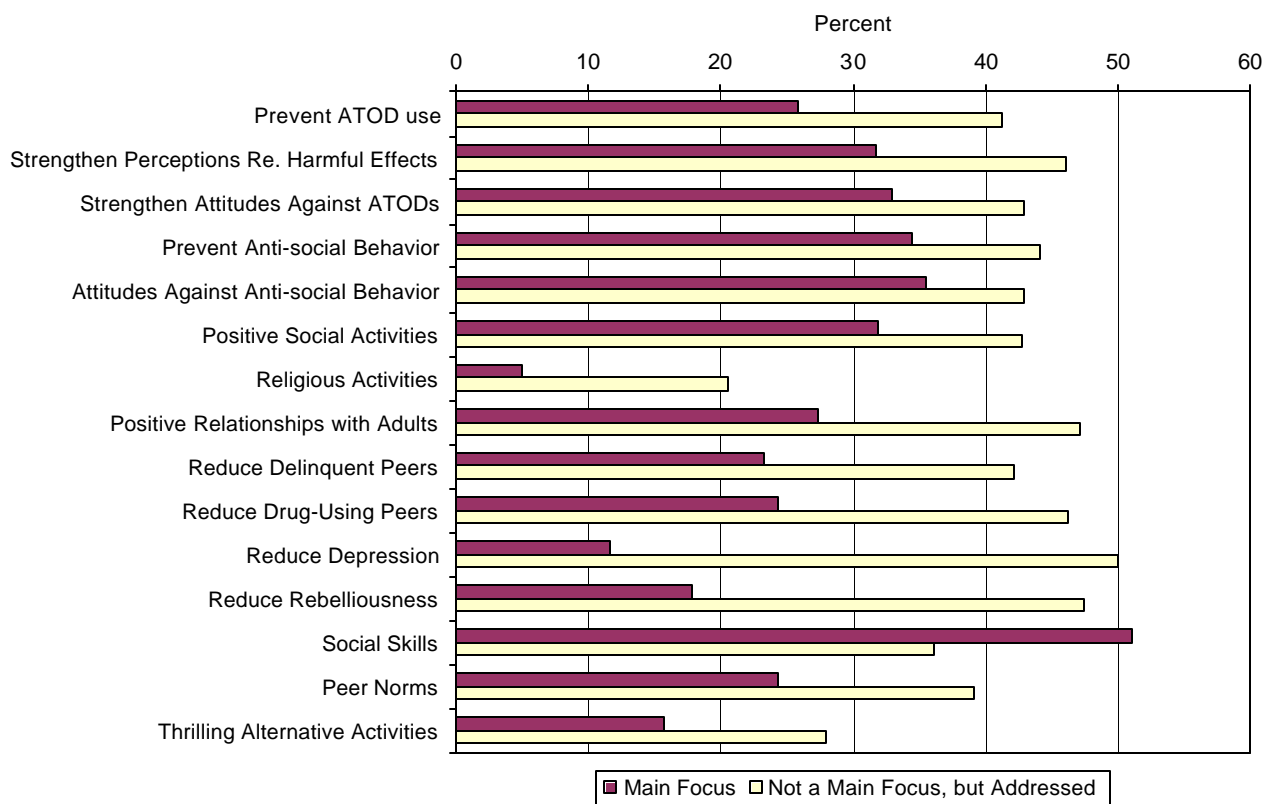
Exhibit 9 presents the Phase II findings for HPR I. Similar to results of the Commonwealth, the most common objective reported to be a main program focus in the peer/individual domain was *improving social skills* (55%), followed by *strengthening perceptions about negative effects of ATOD use* (37.5%) and *strengthening attitudes against antisocial behaviors* (35.7%).

Exhibit 9
HPR I Program Goals and Objectives—Peer/Individual Domain:
Phase II Respondents
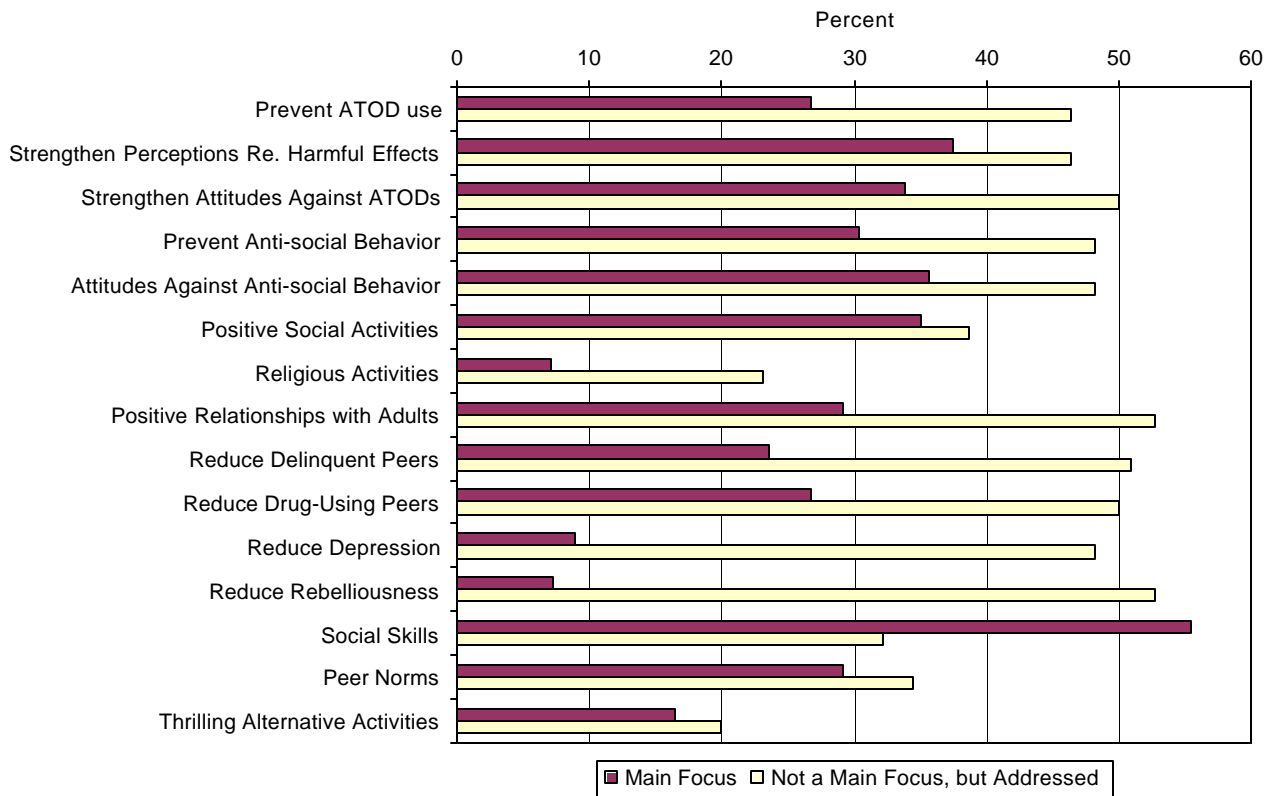
Exhibit 10 presents the Phase II findings for HPR II. In HPR II, again, the most commonly reported objective was *improving social skills* (50%), followed by *preventing antisocial behaviors* (37.5%) and *strengthening attitudes against antisocial behaviors* (31.3%).

Exhibit 10
HPR II Program Goals and Objectives—Peer/Individual Domain:
Phase II Respondents
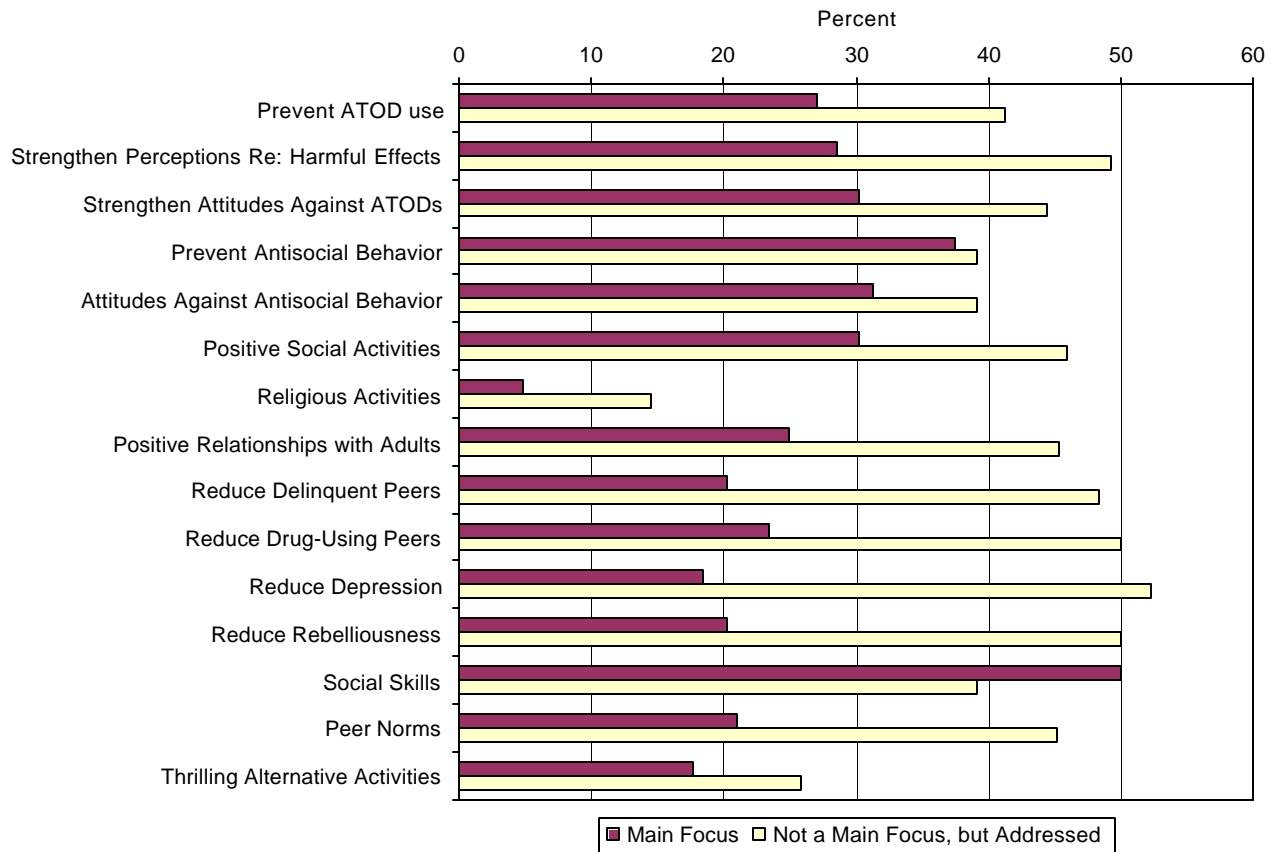
Exhibit 11 presents the Phase II findings in HPR III. In HPR III, *improving social skills* (60.6%) was the most commonly reported program objective, followed by *strengthening attitudes against antisocial behaviors* (43.5%) and *strengthening perceptions about harmful effects of ATOD use* (40.6%).

Exhibit 11
HPR III Program Goals and Objectives—Peer/Individual Domain:
Phase II Respondents
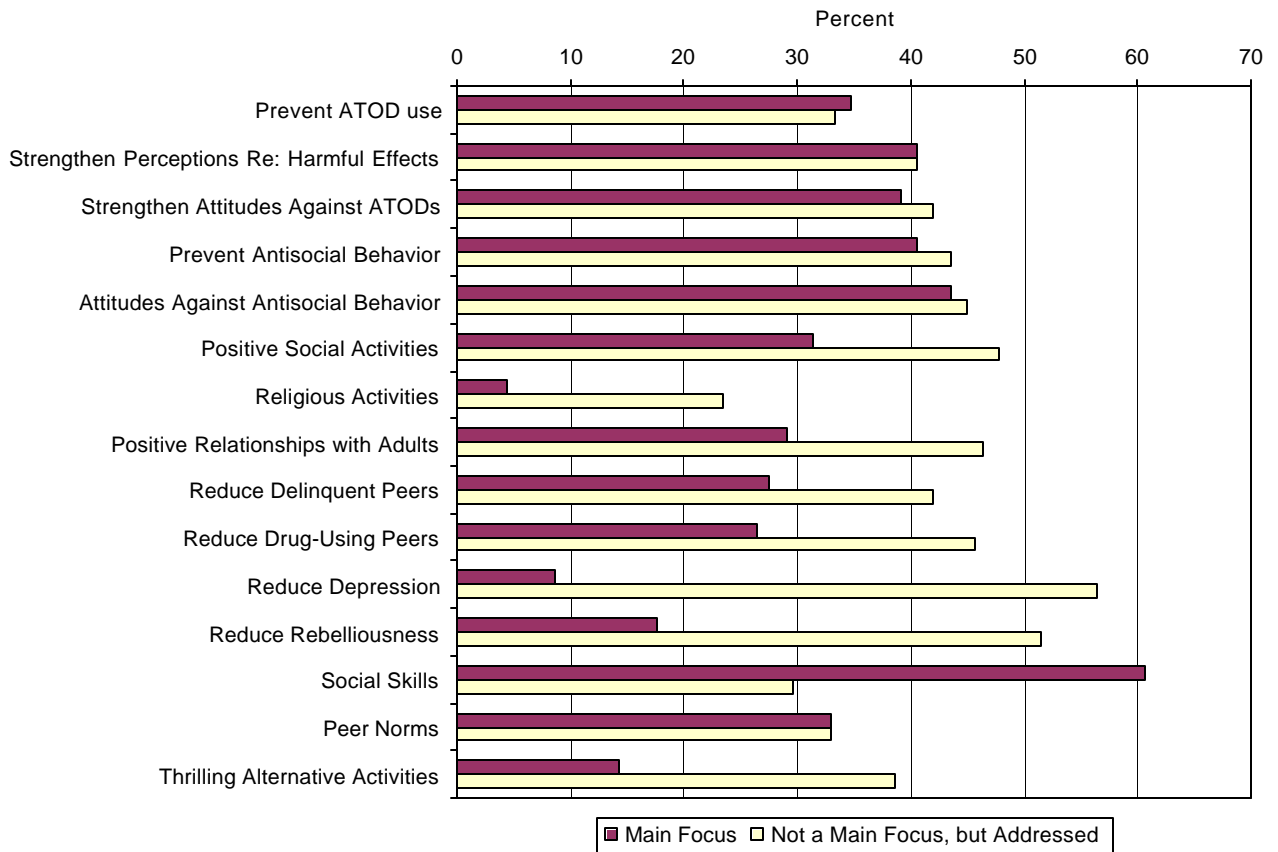
Exhibit 12 presents the Phase II findings for HPR IV. In HPR IV, the most commonly reported objective was *increasing social skills* (54.7%), followed by *strengthening attitudes against ATOD use* (39.6%) and *preventing antisocial behaviors* (36.7%).

Exhibit 12
HPR IV Program Goals and Objectives—Peer/Individual Domain:
Phase II Respondents
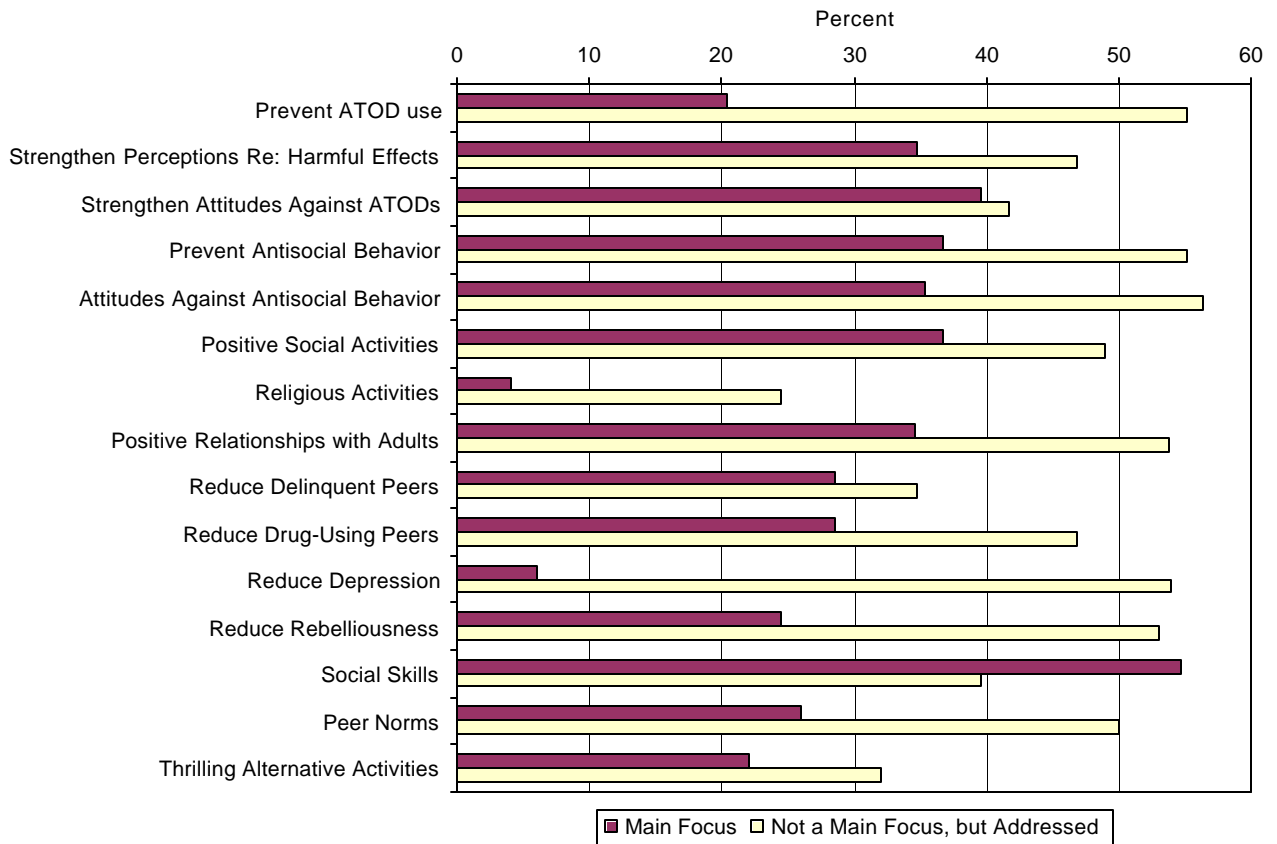
Exhibit 13 presents the Phase II findings for HPR V. In HPR V, the most common objective reported to be a main program focus was *increasing social skills* (41.9%), followed by *strengthening attitudes against antisocial behavior* (36.1%).

Exhibit 13
HPR V Program Goals and Objectives—Peer/Individual Domain:
Phase II Respondents
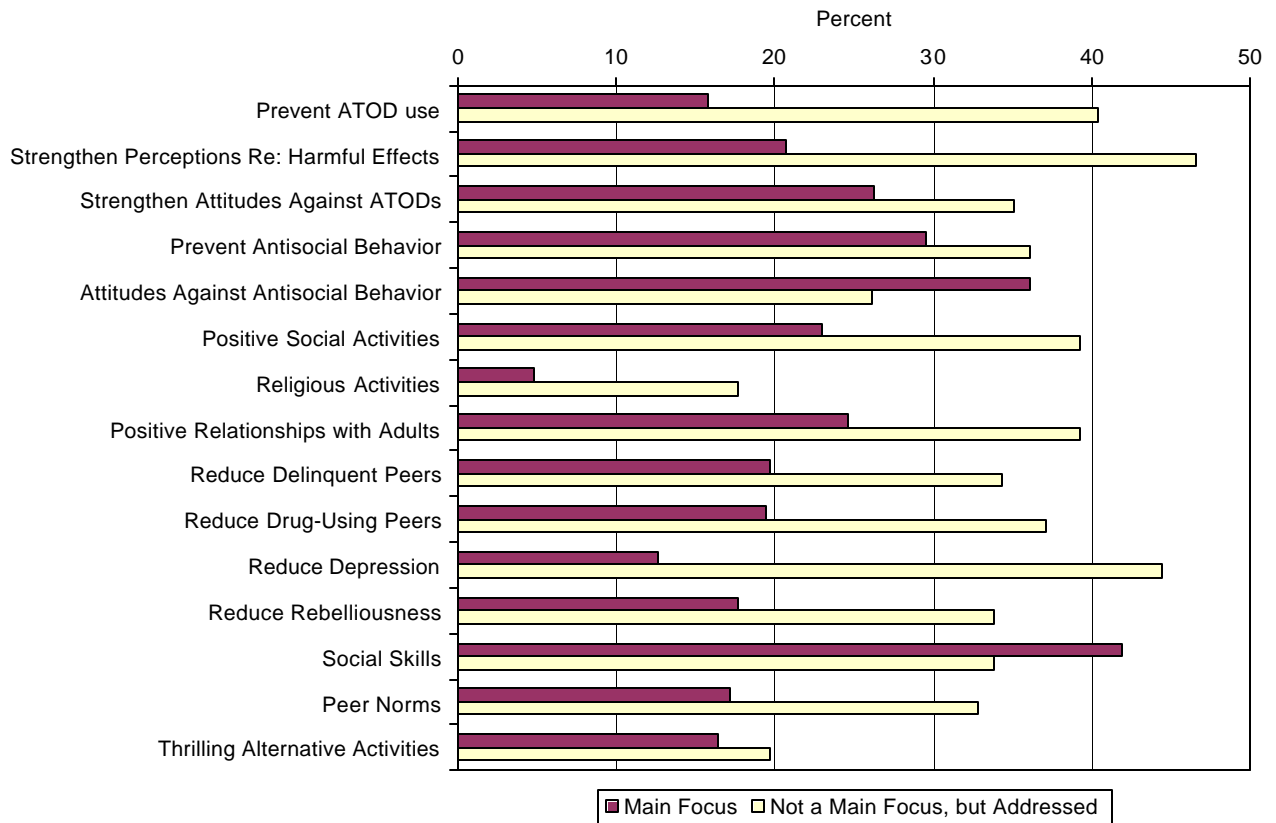
Family Domain

Exhibit 14 presents the family domain findings for the Commonwealth. The two most common objectives reported to be a main program focus were *improving family communication skills* (39.7%) and *improving family management skills* (35.4%). The third most common objective reported by respondents as a main program objective was *improving parents' ability for pro-social family involvement* (31.7%).

Exhibit 14. Commonwealth Program Goals and Objectives—Family Domain: Phase II Respondents
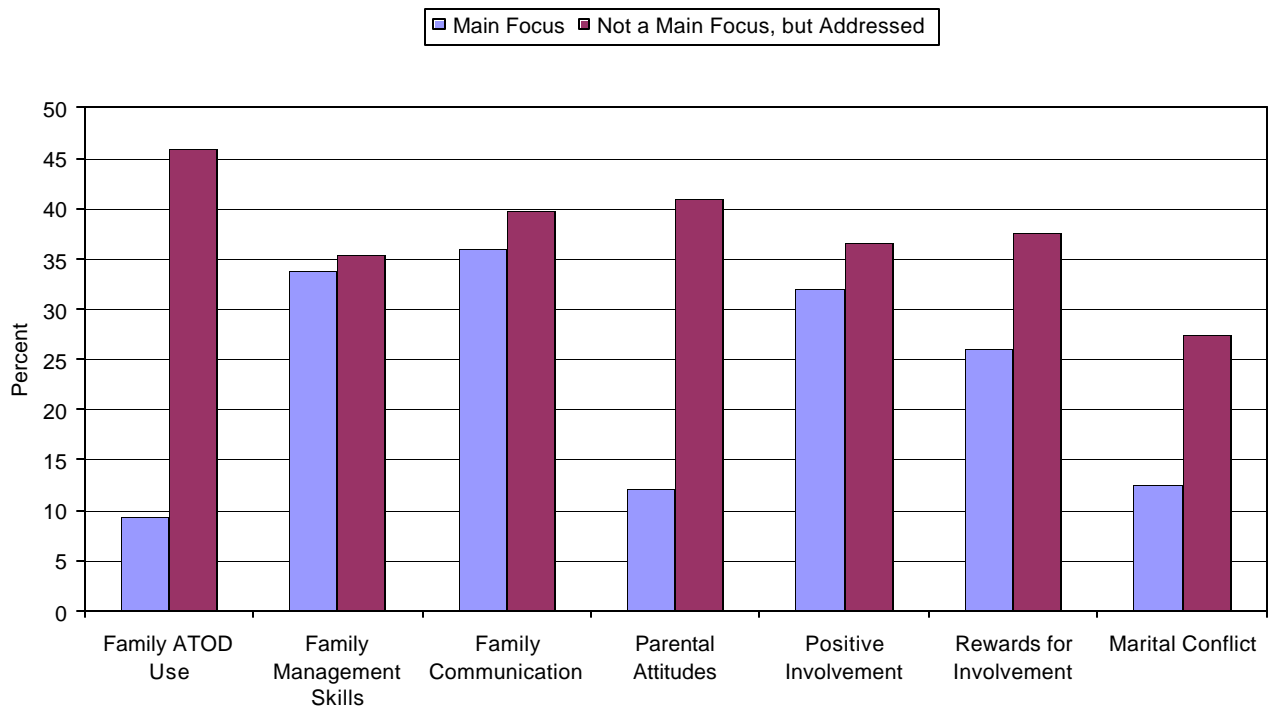
Exhibit 15 presents the findings for HPR I. In HPR I, the most common objective was *improving parents' ability for pro-social family involvement* (29.1%). The second most commonly reported main program objective in the family domain was *improving family management skills* (26.8%), followed closely by *improving family communication skills* (26.3%). It should be noted that less than 30 percent of respondents endorsed any of the objectives in the family domain as being a main program focus.

Exhibit 15
HPR I Program Goals and Objectives—Family Domain: Phase II Respondents
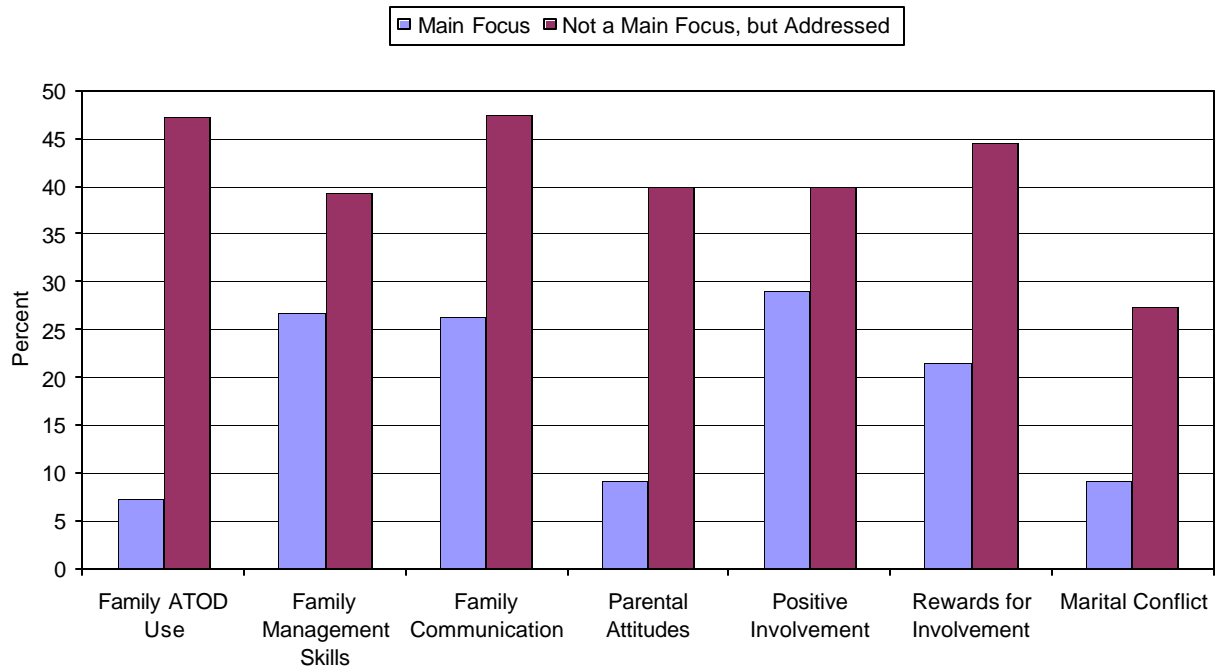
Exhibit 16 presents the findings for HPR II. In HPR II, the most common family domain objective was *improving parental ability for pro-social family involvement* (35.9%), followed by *increasing parental ability to reward positive family involvement* (31.7%).

Exhibit 16
HPR II Program Goals and Objectives—Family Domain: Phase II Respondents
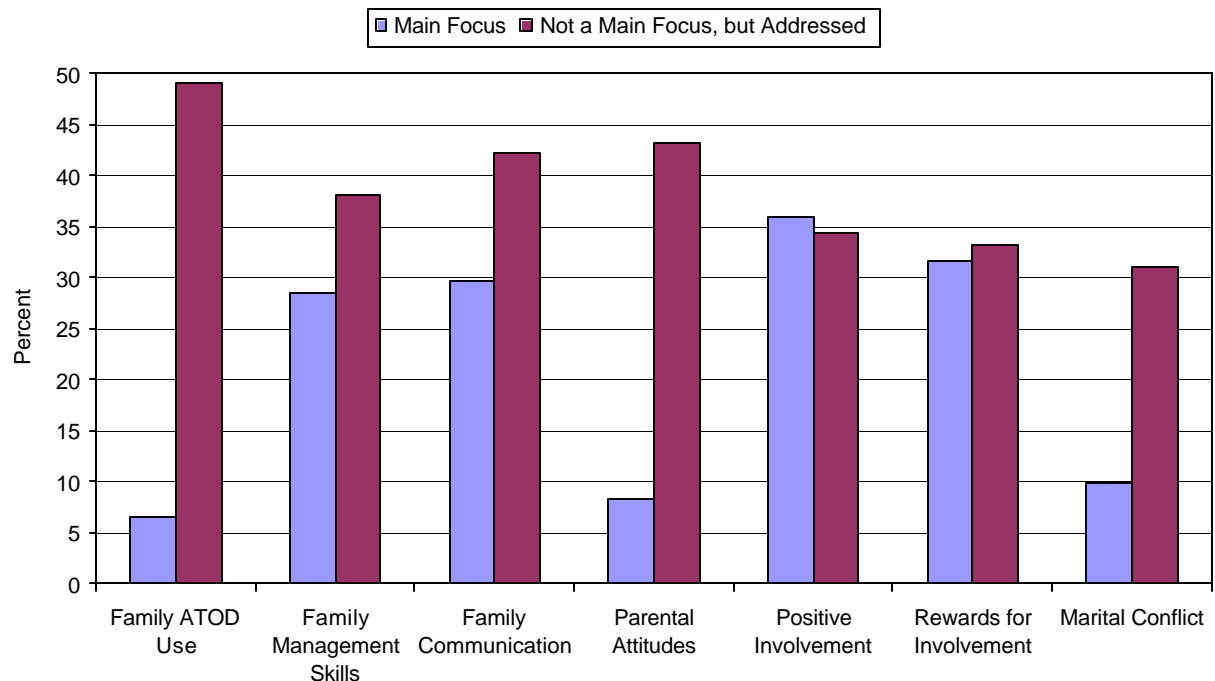
Exhibit 17 presents the findings for HPR III. *Improving family communication skills* was the most commonly reported family domain objective in HPR III (45%), followed by *improving family management skills* (38.6%).

Exhibit 17
HPR III Program Goals and Objectives—Family Domain: Phase II Respondents
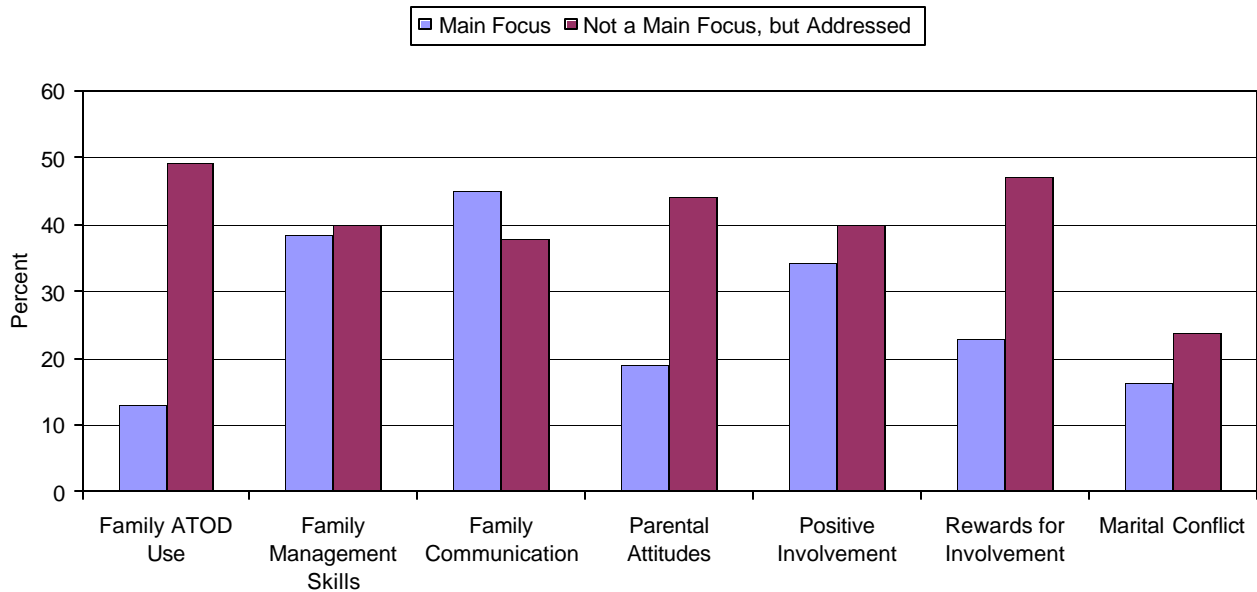
Exhibit 18 presents the findings for HPR IV. The most commonly reported main objective within the family domain was *improving family communication skills* in HPR IV (45%). Forty-two percent of respondents reported that *improving family management skills* was a main objective of their program, the second most commonly reported objective.

Exhibit 18
HPR IV Program Goals and Objectives—Family Domain: Phase II Respondents
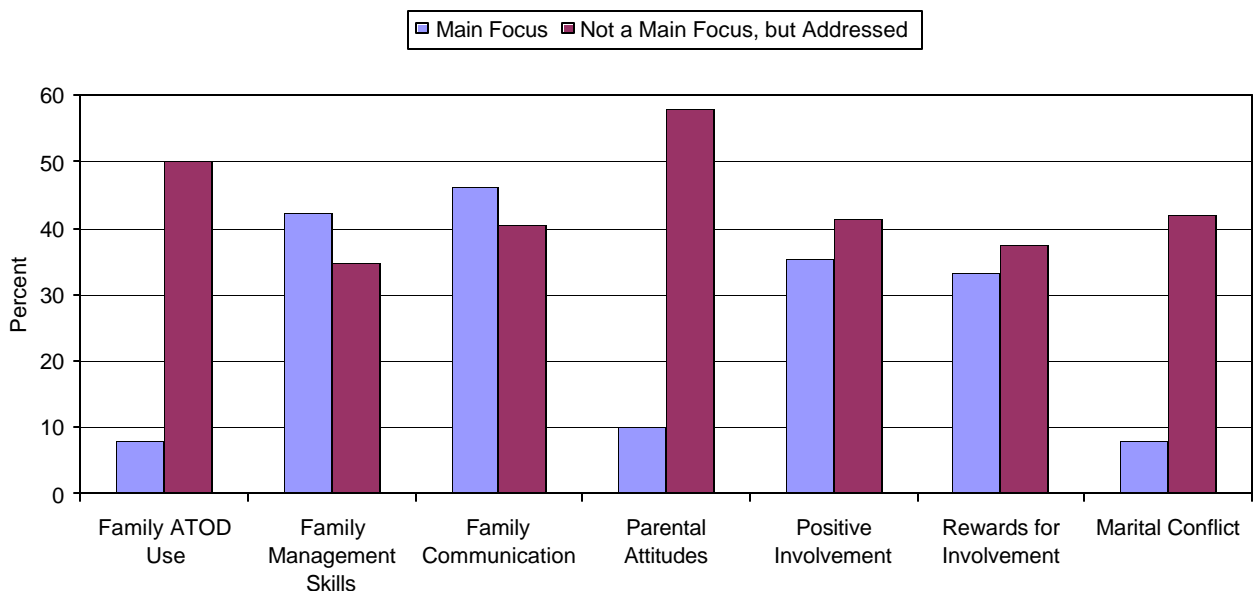
Exhibit 19 presents the findings for HPR V. The most commonly reported family domain objective in HPR V was *improving family management skills* (28.8%). The second most commonly reported objective by respondents in HPR V was *improving family communication skills* (28.3%). It should be noted that less than 30 percent of all respondents in HPR V reported that objectives in the family domain were main program foci.

Exhibit 19
HPR V Program Goals and Objectives—Family Domain: Phase II Respondents
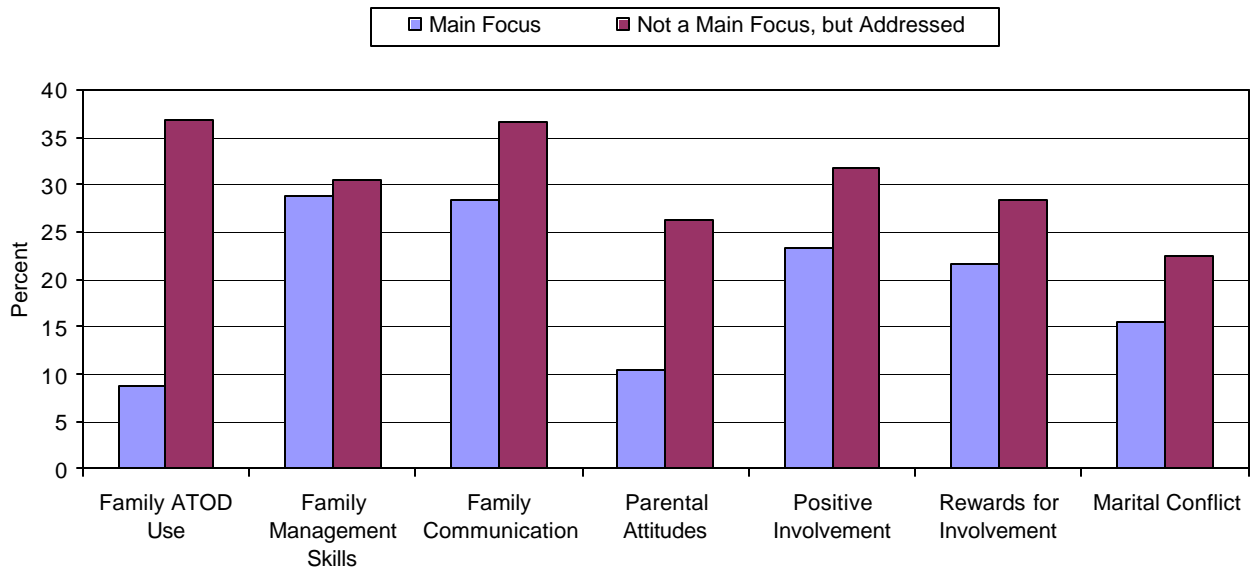
School Domain

Exhibit 20 presents the findings for the Commonwealth. In the Commonwealth, less than one-third of all respondents reported that program objectives in the school domain were a main focus of their programs. The most commonly reported school domain objective was *increasing opportunities for pro-social involvement in the schools* (29.4%), followed by *increasing school commitment* (29%).

Exhibit 20. Commonwealth Program Goals and Objectives—School Domain: Phase II Respondents
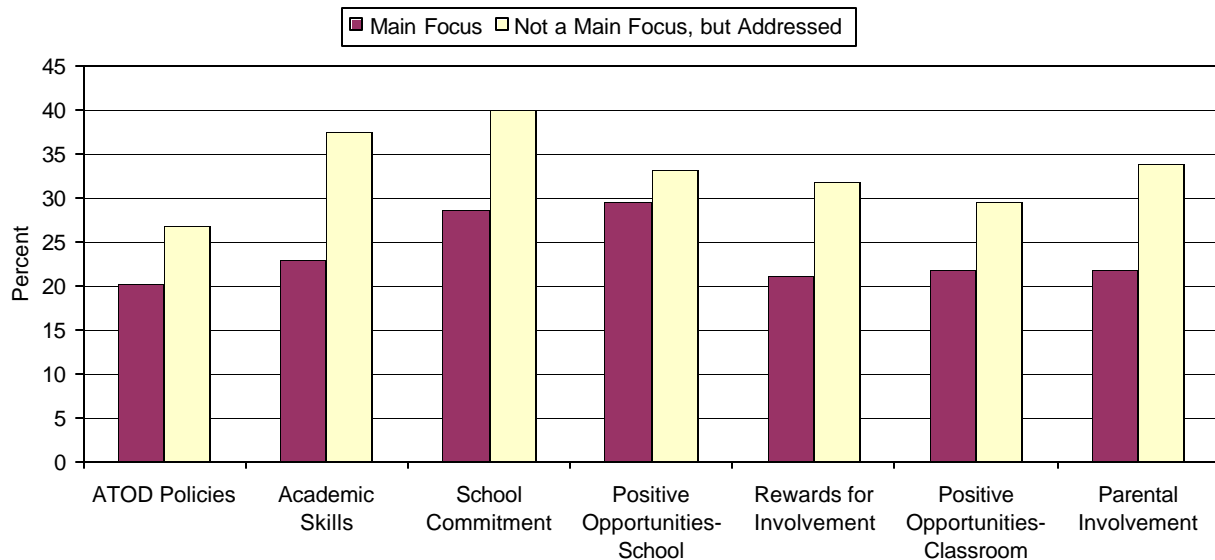
Exhibit 21 presents the findings for HPR I. The most common school domain objective reported by respondents in HPR I was *increasing opportunities for positive youth participation in the schools* (26%), followed by *school commitment* (25.5%), which was endorsed by approximately one-fourth of the respondents.

Exhibit 21.
HPR I Program Goals and Objectives—School Domain: Phase II Respondents
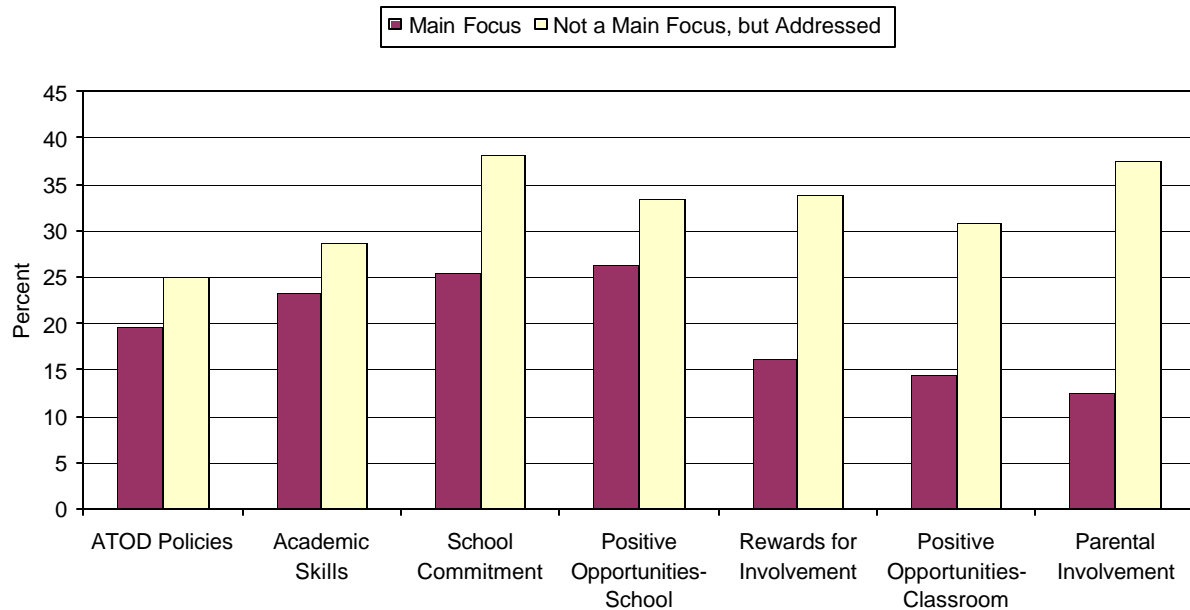
Exhibit 22 presents the findings for HPR II. The most commonly reported school domain objectives in HPR II were *increasing school commitment* (28.3%) and *increasing opportunities for positive school involvement* (28.3%).

Exhibit 22.
HPR II Program Goals and Objectives—School Domain: Phase II Respondents
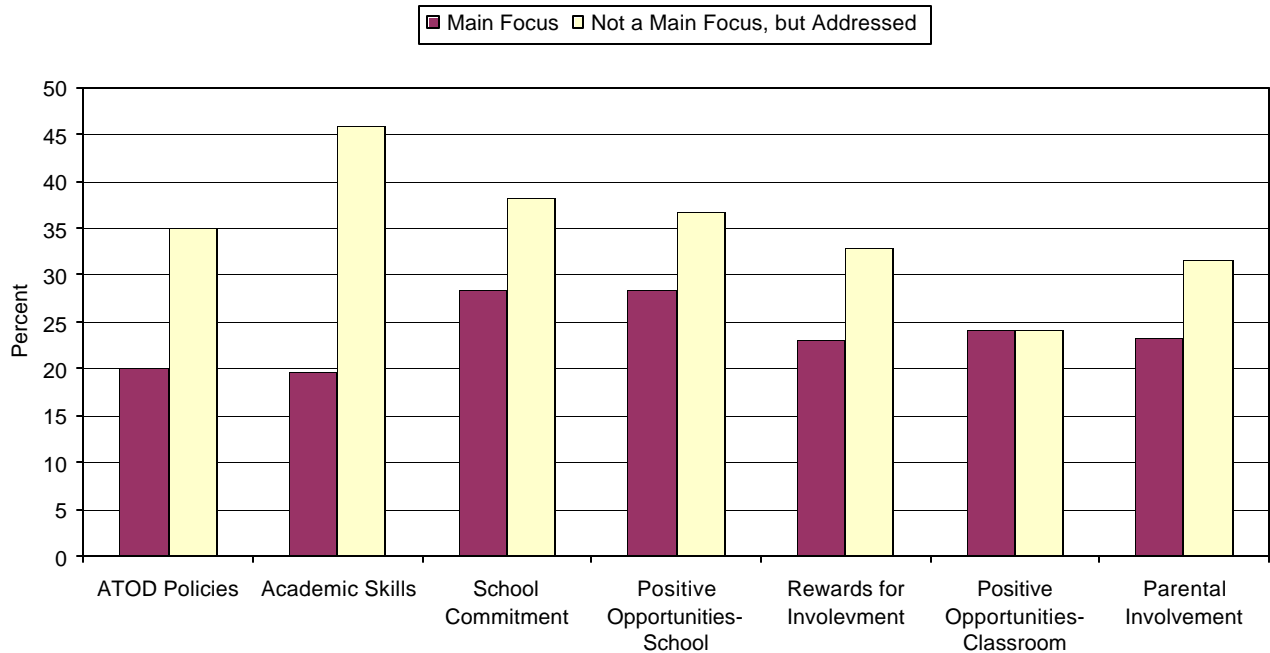
Exhibit 23 presents the findings for HPR III. Again, the most commonly reported school domain objective was *increasing opportunities for positive school involvement* (29%). The second most commonly reported objective was *improving school commitment* (28%).

Exhibit 23.
HPR III Program Goals and Objectives—School Domain: Phase II Respondents
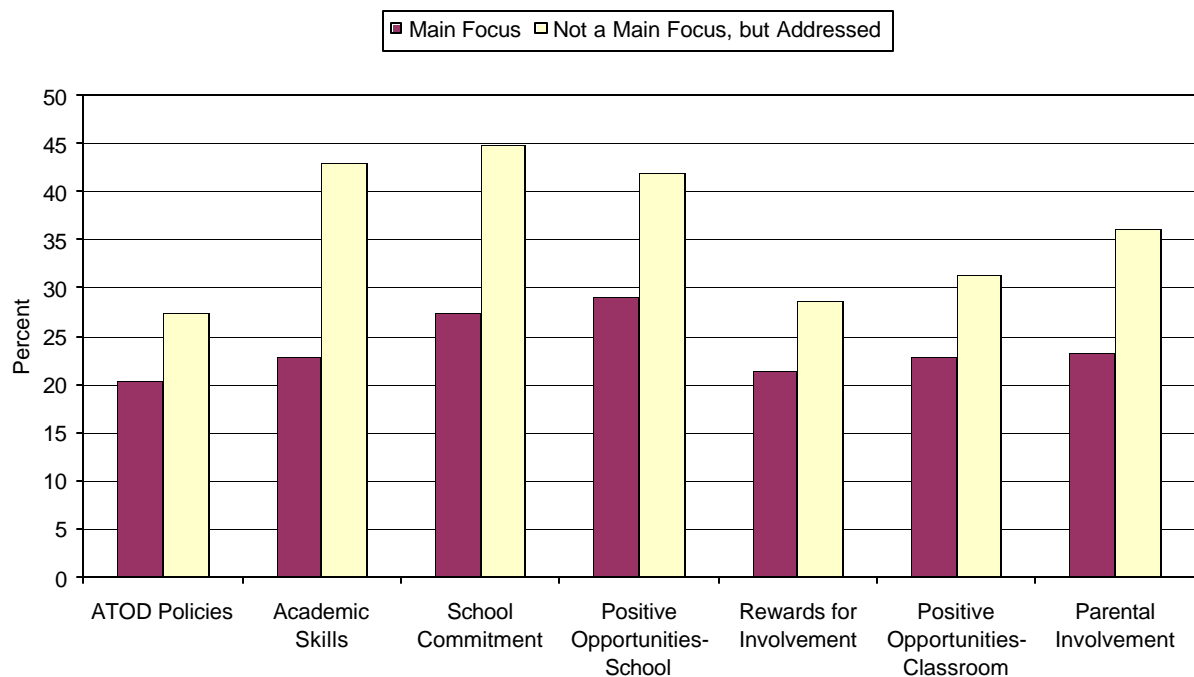
Exhibit 24 presents the findings for HPR IV. More respondents in HPR IV were likely to report that objectives in the school domain were a main program focus compared to the other HPRs. Almost half of the respondents reported that *increasing opportunities for positive school involvement* was a main program objective. The second most commonly reported main program objective in HPR V was *increasing school commitment* (38.5%), followed closely by *increasing parental involvement in school activities* (37%).

Exhibit 24.
HPR IV Program Goals and Objectives—School Domain: Phase II Respondents
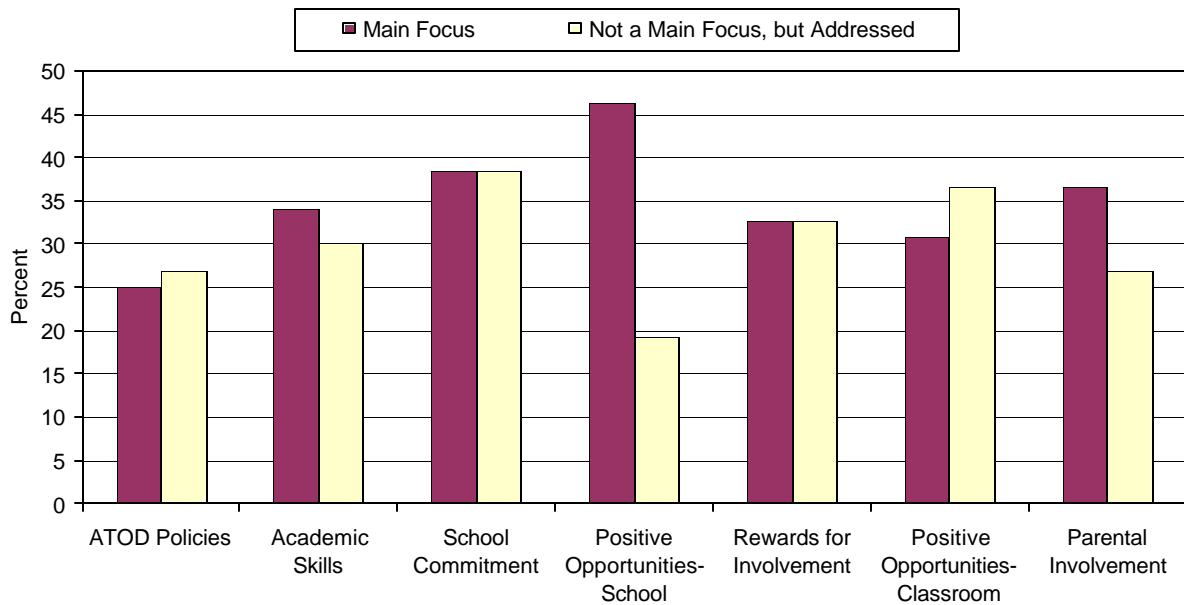
Exhibit 25 presents the findings for HPR V. The most commonly reported school domain objective was *increasing school commitment*, with 22 percent of the respondents reporting that this was a main program objective. The second most commonly reported school domain program objective was *increasing positive opportunities for school involvement* (16.1%).

**Exhibit 25. HPR V Program Goals and Objectives—School Domain:
Phase II Respondents**
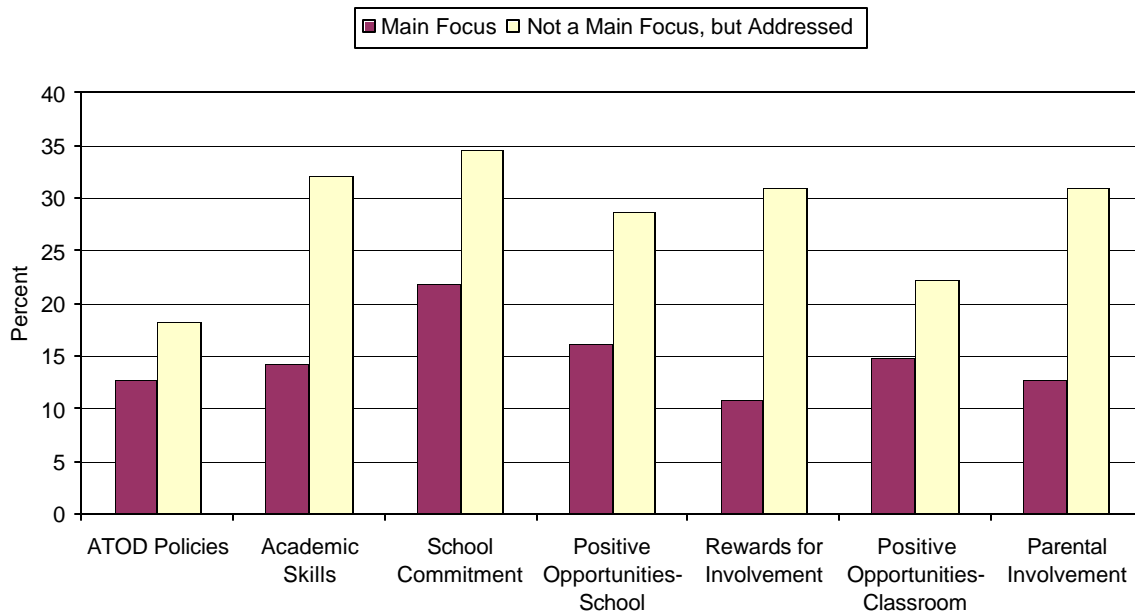
Community Domain

Exhibit 26 presents the findings for the Commonwealth. Less than one-fourth of all respondents indicated that program objectives in the community domain were a main focus of their programs. The most commonly reported community domain objective was *increasing opportunities for positive youth involvement in the community* (23.5%).

**Exhibit 26. Commonwealth Program Goals and Objectives—Community Domain:
Phase II Respondents**
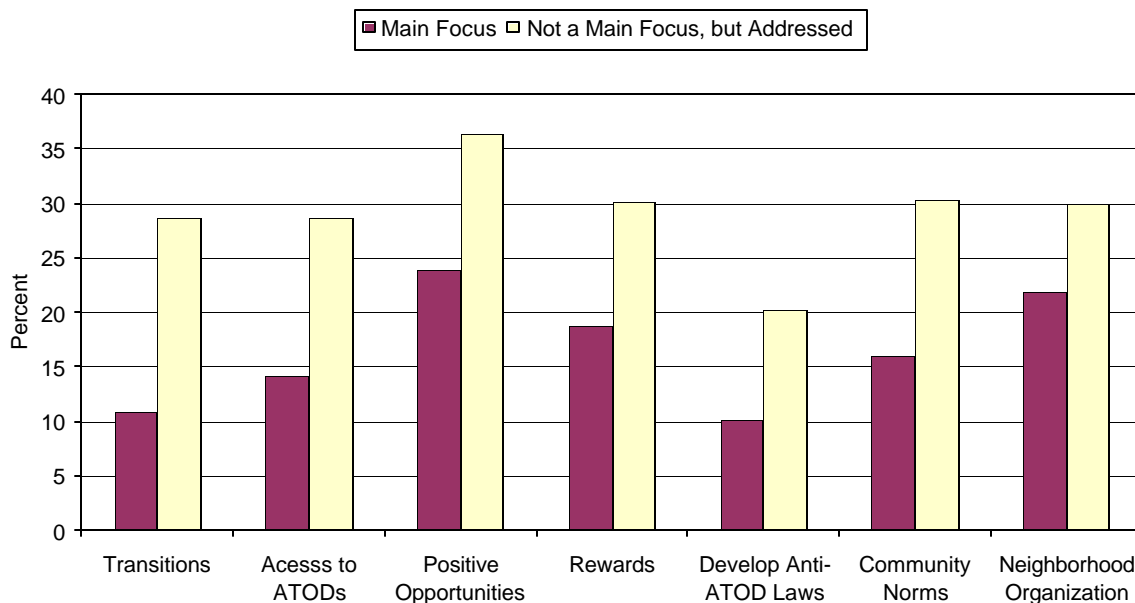
Exhibit 27 presents the findings for HPR I. The most common objective in HPR I was *increasing opportunities for positive youth involvement in the community* (25.0%). The second most commonly reported main program objective was *strengthening community norms and/or attitudes against ATOD use* (23.2%).

Exhibit 27.
HPR I Program Goals and Objectives—Community Domain: Phase II Respondents
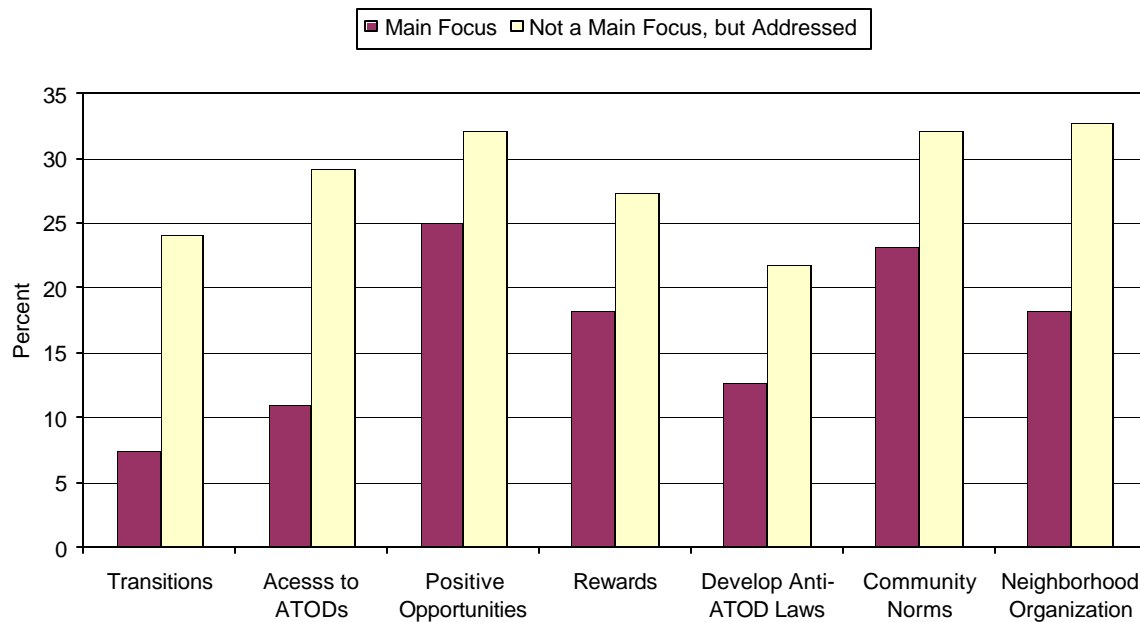
Exhibit 28 presents the findings for HPR II. The most commonly reported objective in the community domain in HPR II was *increasing rewards for positive involvement in the community* (31%). Approximately 30 percent of respondents reported that *increasing positive opportunities for youth involvement in the community* was a main program objective.

Exhibit 28.
HPR II Program Goals and Objectives—Community Domain: Phase II Respondents
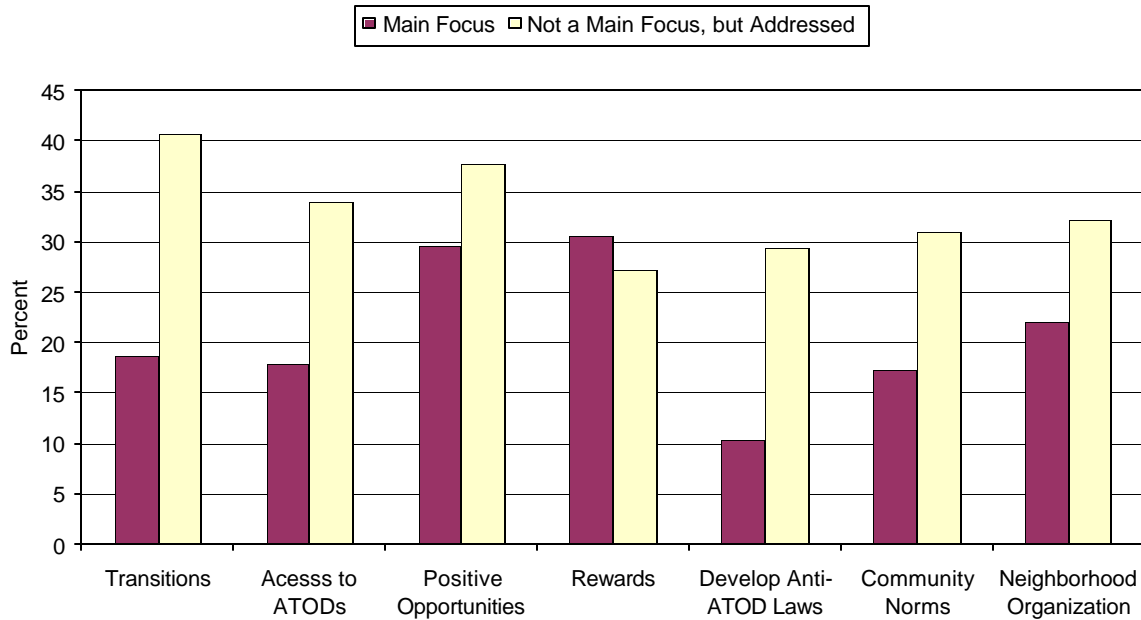
Exhibit 29 presents the findings for HPR III. The most commonly reported community domain objective in HPR III was *improving neighborhood safety, organization, or sense of community* (20.9%).

Exhibit 29.
HPR III Program Goals and Objectives—Community Domain: Phase II Respondents
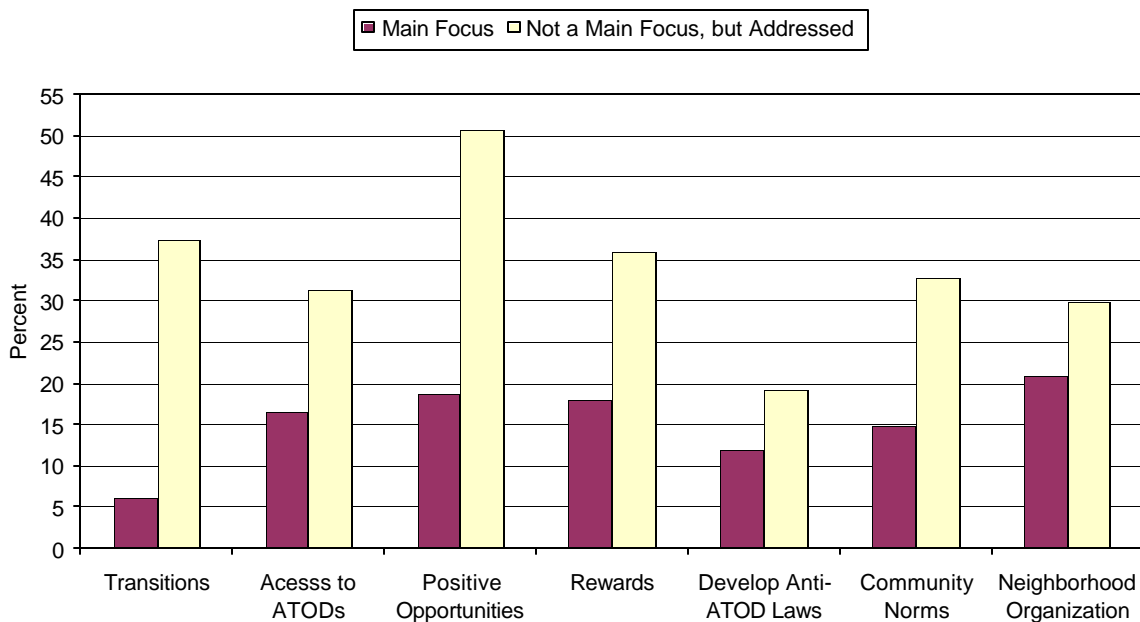
Exhibit 30 presents the findings for HPR IV. Thirty percent of respondents in HPR IV reported that *increasing positive community involvement* was a main

objective of their program, followed by *improving neighborhood safety, organization, or sense of community* (27.5%).

Exhibit 30.
HPR IV Program Goals and Objectives—Community Domain: Phase II Respondents
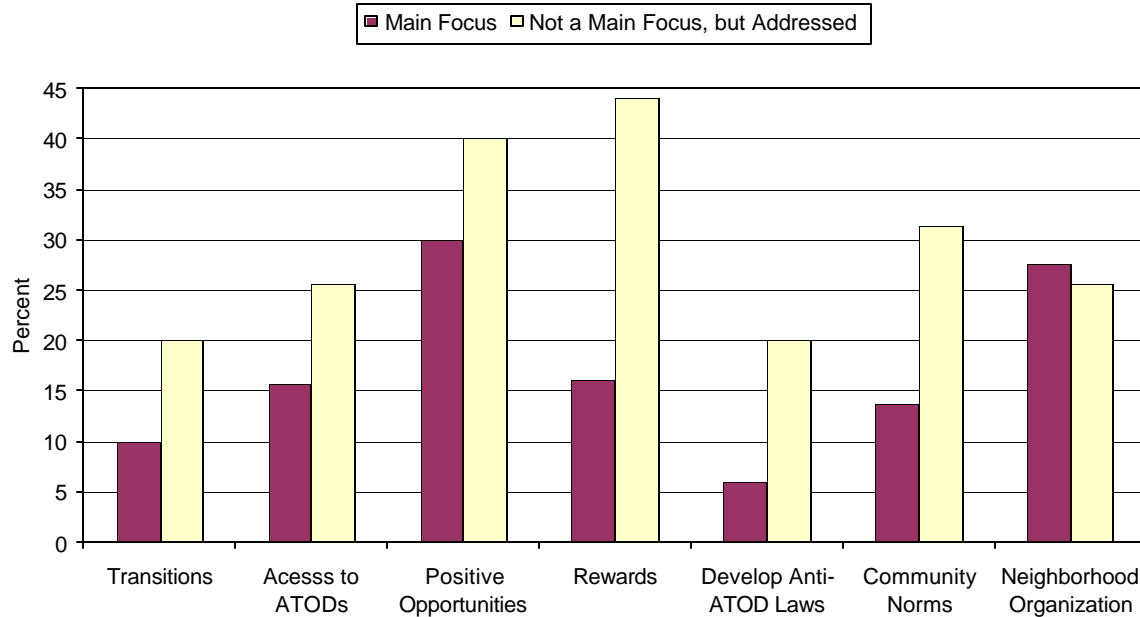
Exhibit 31 presents the findings for HPR V. The most common community domain objective in HPR V was *improving neighborhood safety, organization, or sense of community* (17.2%), followed by *increasing positive community involvement* (15.5%).

Exhibit 31.
HPR V Program Goals and Objectives—Community Domain: Phase II Respondents
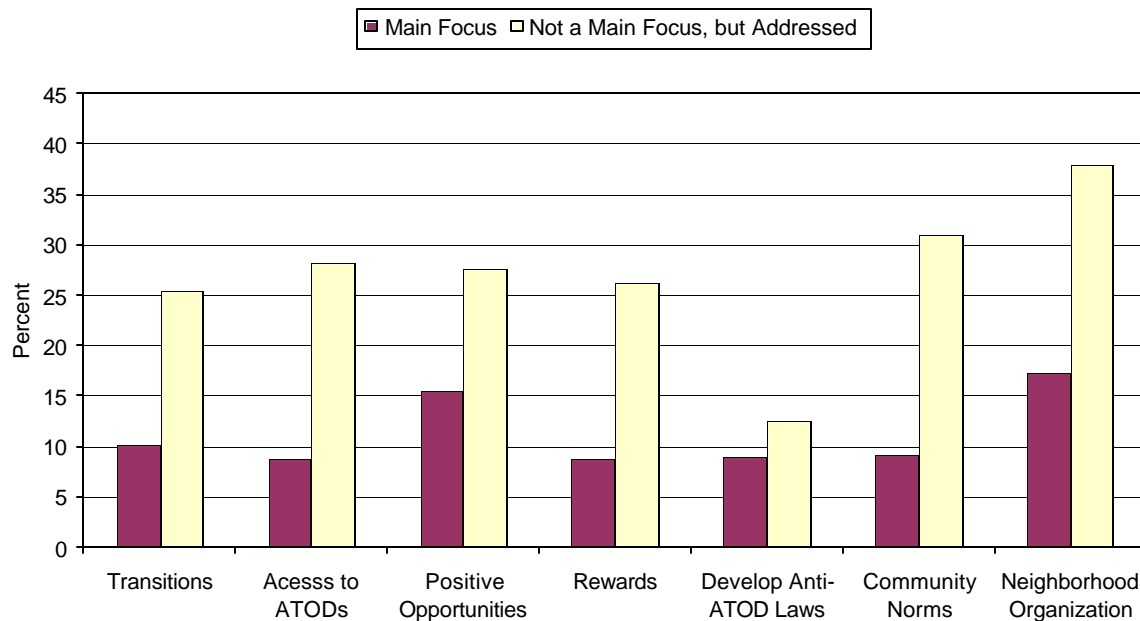
SERVICES PROVIDED

To collect information on the types of services provided by State and local programs, Phase I and Phase II respondents were asked to indicate which types of services their office/program provided. The findings are categorized into services provided within the individual, family, school, and community domains.

Individual Domain

Exhibit 32 presents the Phase I findings on services provided in the individual domain. The most common service within the individual domain reported by Phase I respondents are Life Skills/Social Skills Training (71.1%), followed by Drug-Free Activities and Mentoring Services (63.2%).

Exhibit 32. Services Provided at the State and Local Level—Individual Domain: Phase I Respondents
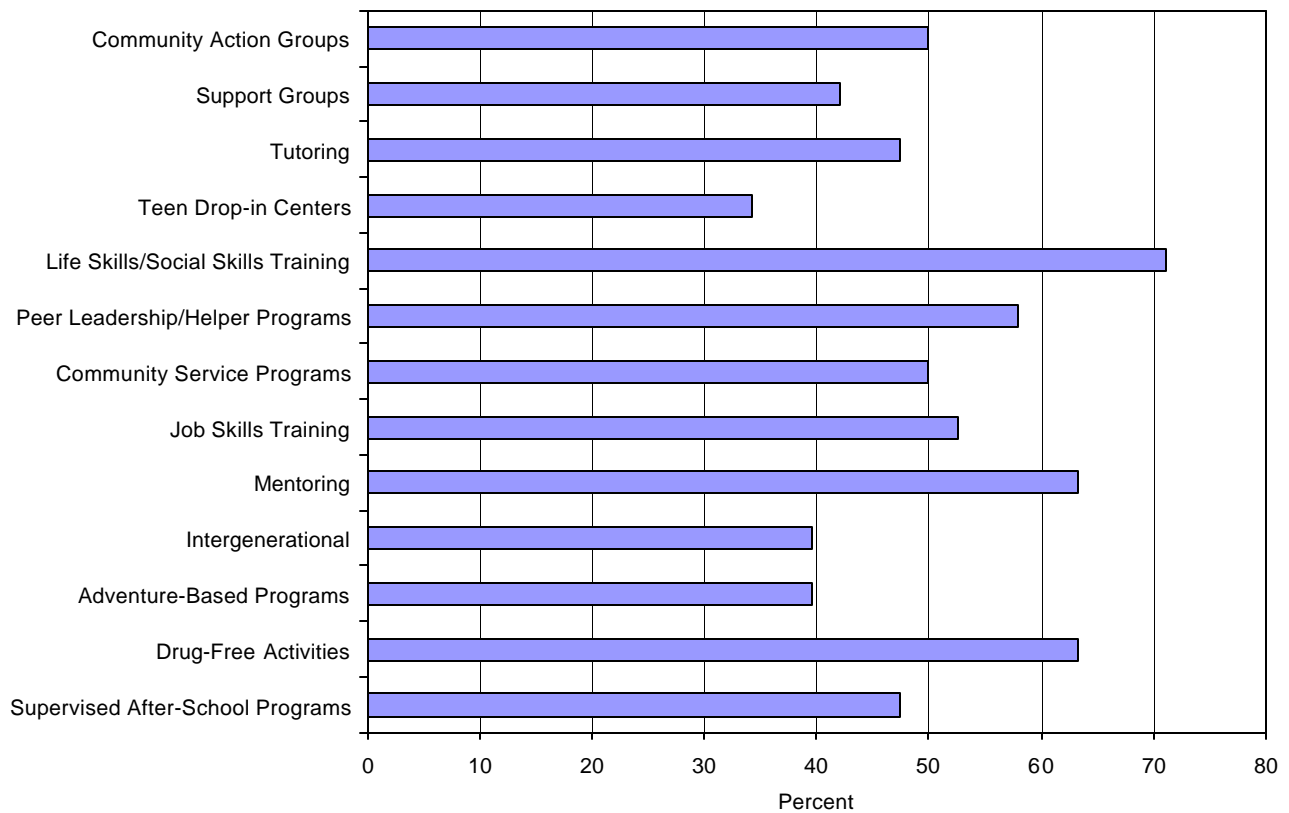
Exhibit 33 presents the Phase II findings on services provided by programs in the Commonwealth. In the Commonwealth, more than half of respondents reported that Life Skills/Social Skills Training (66.7%), Mentoring (54.4%), and Youth Community Service Programs (51.4%) were provided by their programs.

Exhibit 33. Commonwealth Programs/Services Provided by Prevention Programs—Individual Domain: Phase II Respondents
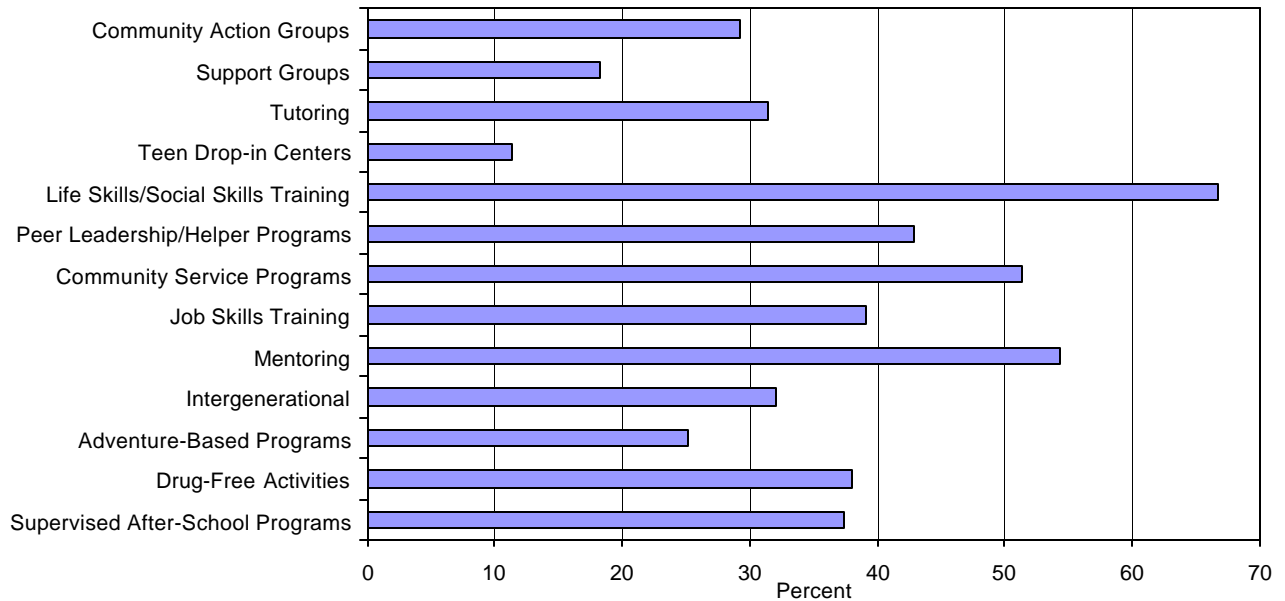
Exhibit 34 presents the Phase II findings for HPR I. At least 50 percent of respondents in HPR I reported that their programs provided Life Skills/Social Skills Training (65.6%), Youth Community Service Programs (51.6%), and Mentoring Services (50%).

Exhibit 34. HPR I Programs/Services Provided by Prevention Programs—Individual Domain: Phase II Respondents
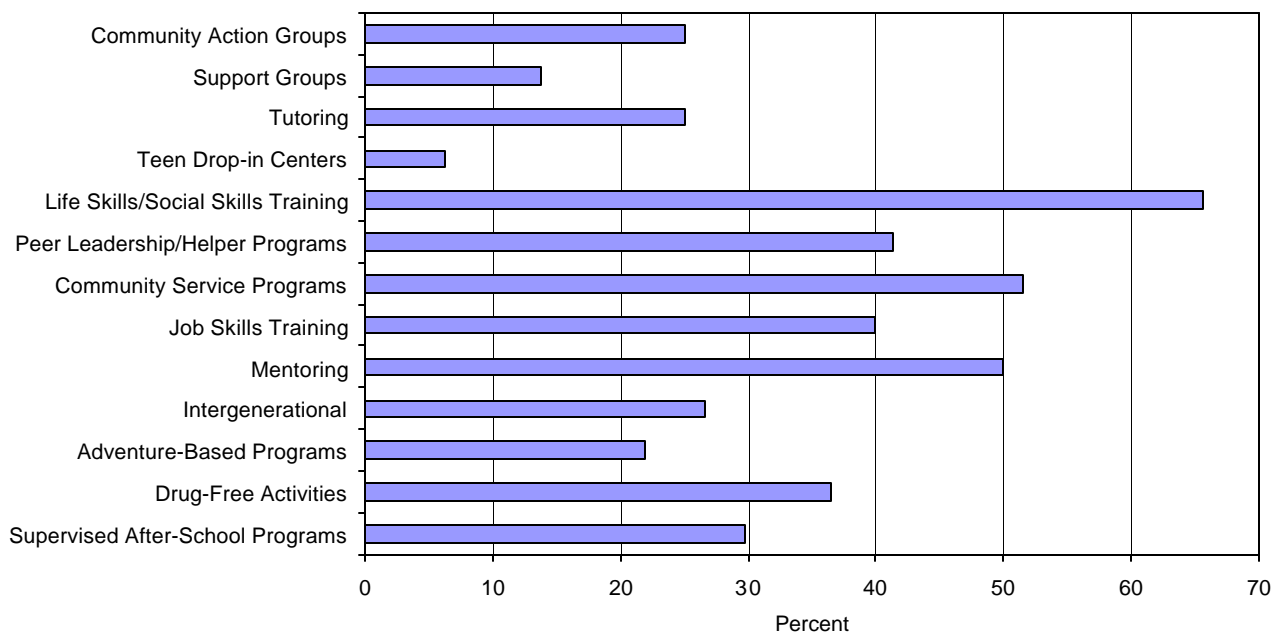
Exhibit 35 presents the Phase II findings for HPR II. The most common service reported by respondents in the individual domain was Life/Social Skills Training (61.3%), followed by Youth Community Service Programs (46.7%) and Mentoring (46.7%).

Exhibit 35
HPR II Programs/Services Provided by Prevention Programs—Individual Domain: Phase II Respondents
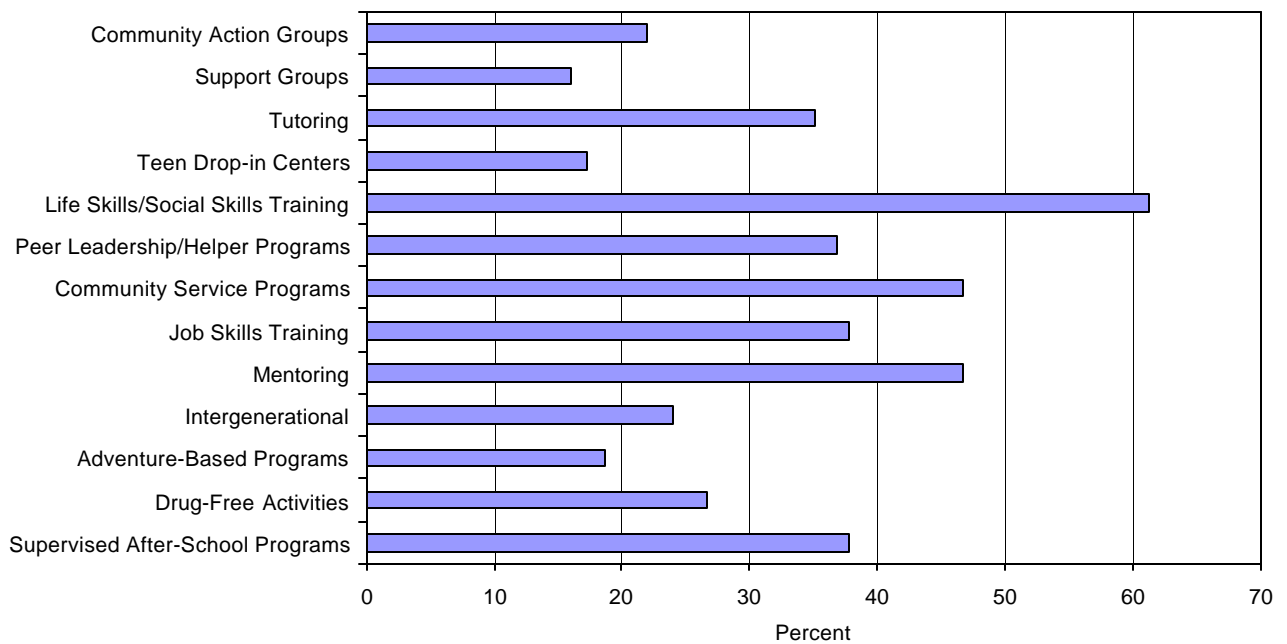
Exhibit 36 presents the findings for HPR III. The most common service within the individual domain reported by respondents in HPR III was Life Skills/Social Skills Training (72%), followed by Mentoring (60.5%) and Community Service Programs (50.7%).

**Exhibit 36. HPR III Programs/Services Provided by Prevention Programs—
Individual Domain: Phase II Respondents**
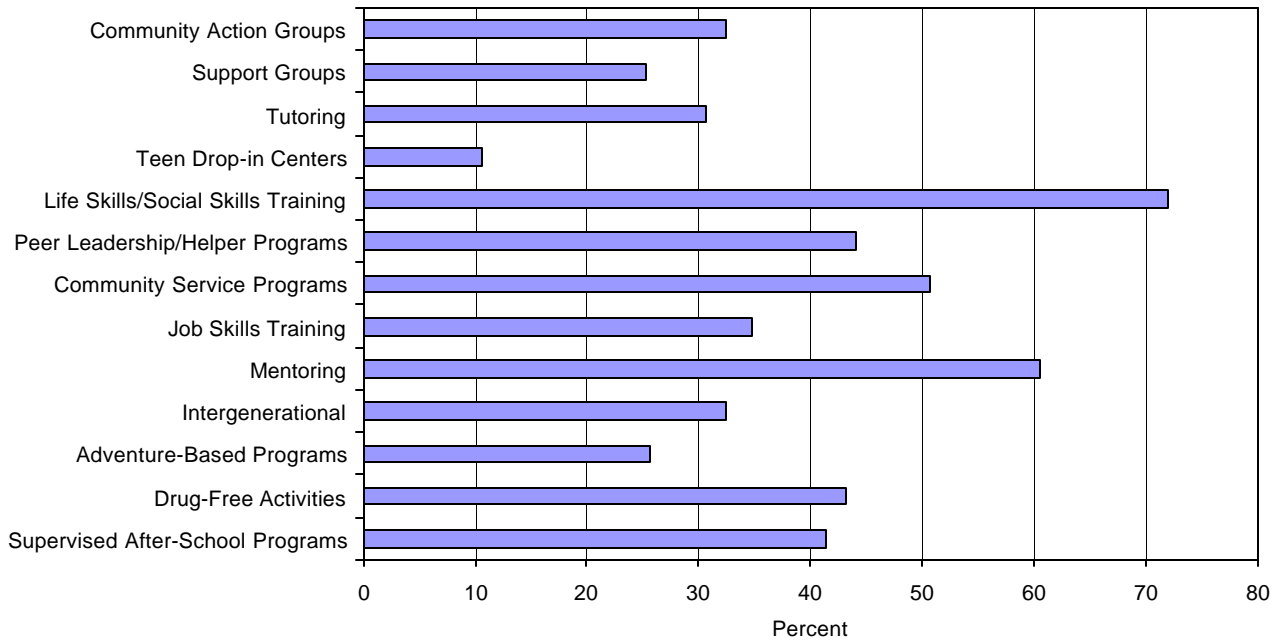
Exhibit 37 presents the findings for HPR IV. The most commonly reported service within the individual domain was Life Skills/Social Skills Training (77.6%), followed by Mentoring (69%) and Youth Community Services (57.9%).

**Exhibit 37. HPR IV Programs/Services Provided by Prevention Programs—
Individual Domain: Phase II Respondents**
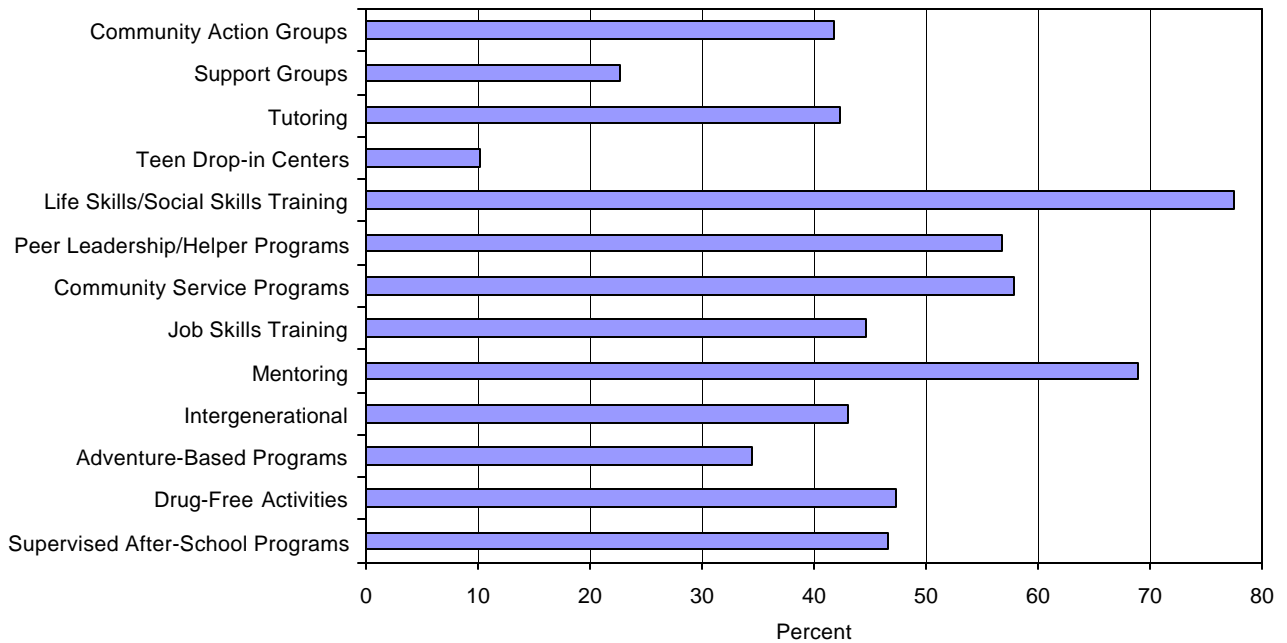
Exhibit 38 presents findings for HPR V. As with the other HPRs, the most common service provided by programs in HPR V was Life Skills/Social Skills Training (61.5%). The second most commonly reported service in the individual domain was Community Service Programs (57.6%), followed by Mentoring (50.8%).

Exhibit 38. HPR V Programs/Services Provided by Prevention Programs— Individual Domain: Phase II Respondents
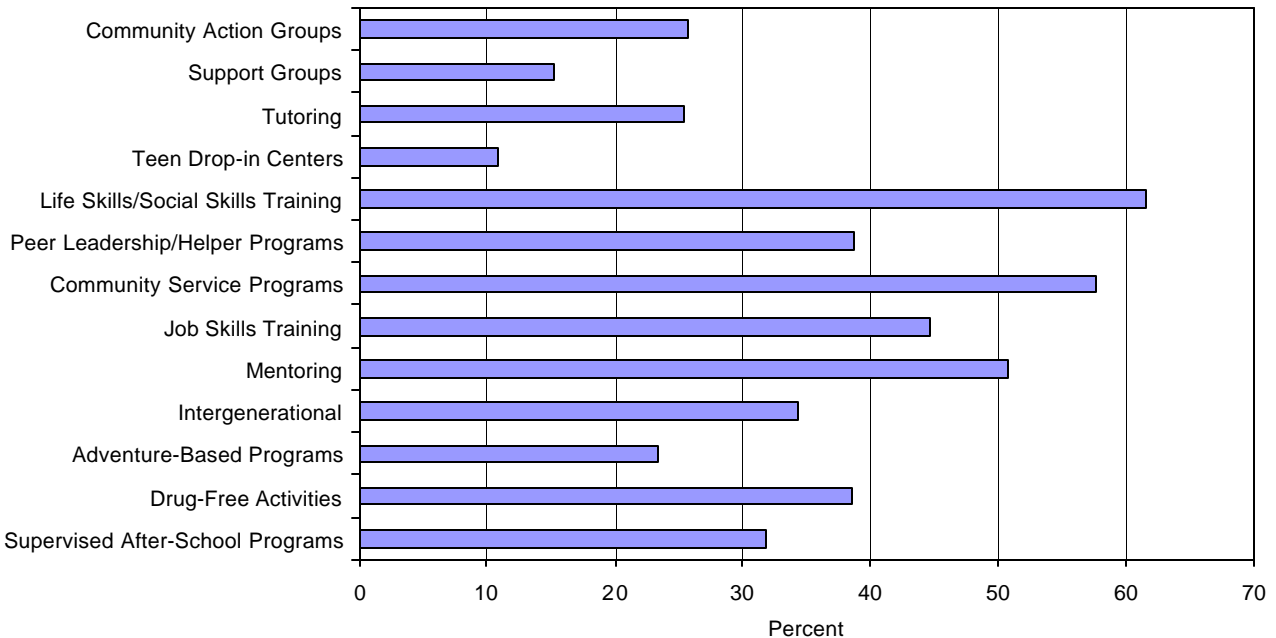
Family Domain

Exhibit 39 presents the Phase I findings on reported services provided in the family domain. The most common service reported by Phase I respondents was Parenting/Family Management Training (63.2%), followed by Prenatal/Infancy Services (53%).

Exhibit 39. Services Provided at the State and Local Level—Family Domain: Phase I Respondents
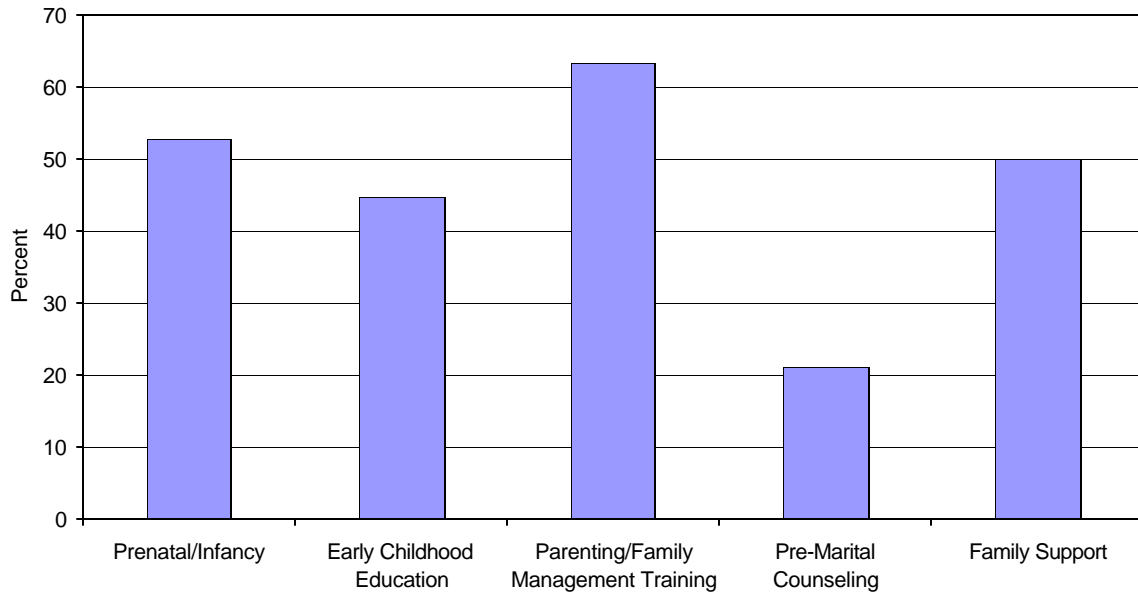
Exhibit 40 presents the findings on services provided in the Commonwealth in the family domain. The most commonly reported service was Parenting/Family Management Training (58.5%), followed by Family Support Services (50.6%).

Exhibit 40. Commonwealth Programs/Services Provided by Prevention Programs— Family Domain: Phase II Respondents
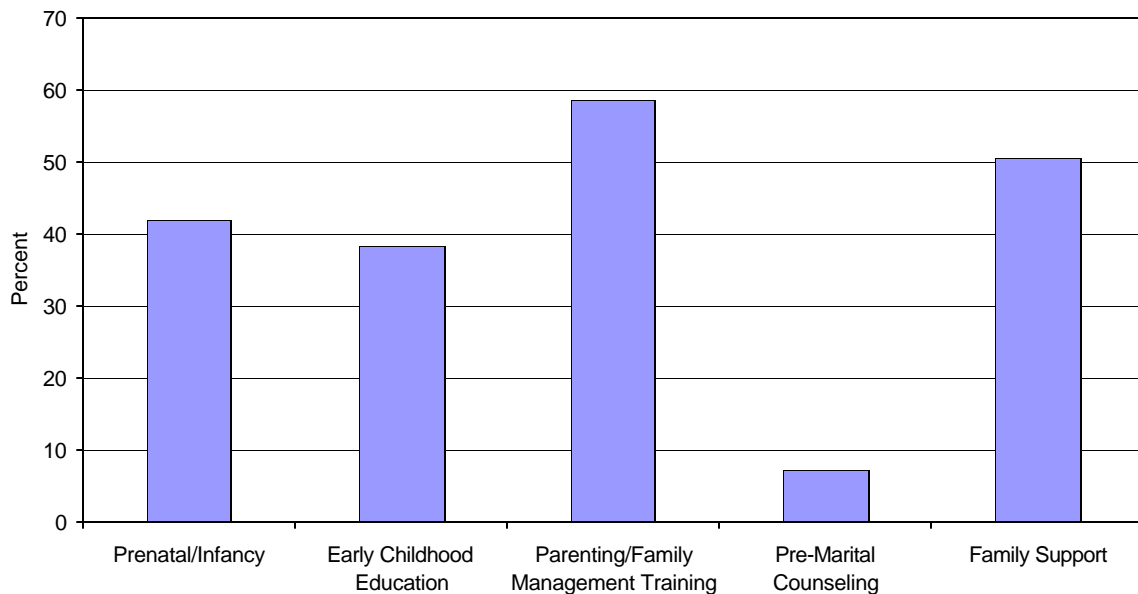
Exhibit 41 presents the findings for HPR I. More than 50 percent of respondents in HPR I reported that their programs provided Parenting/Family Management Training (53.3%), followed by Family Support (45.2%).

Exhibit 41. HPR I Programs/Services Provided by Prevention Programs— Family Domain: Phase II Respondents
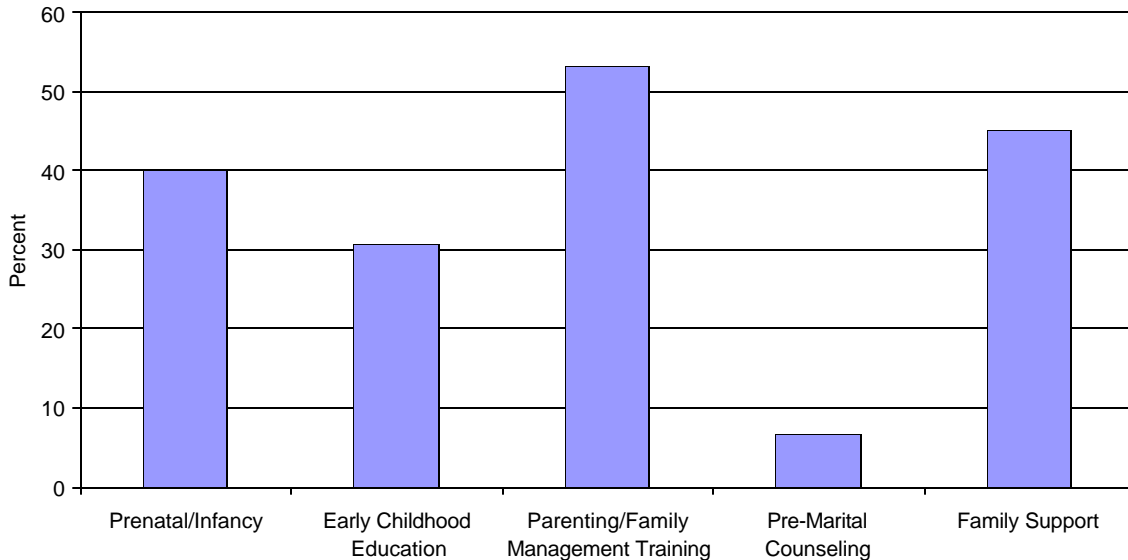
Exhibit 42 presents the findings for HPR II. More than 50 percent of respondents in HPR II reported that Parenting/Family Management Training was a service provided by their programs (52%), followed by Family Support (42.7%).

Exhibit 42. HPR II Programs/Services Provided by Prevention Programs— Family Domain: Phase II Respondents
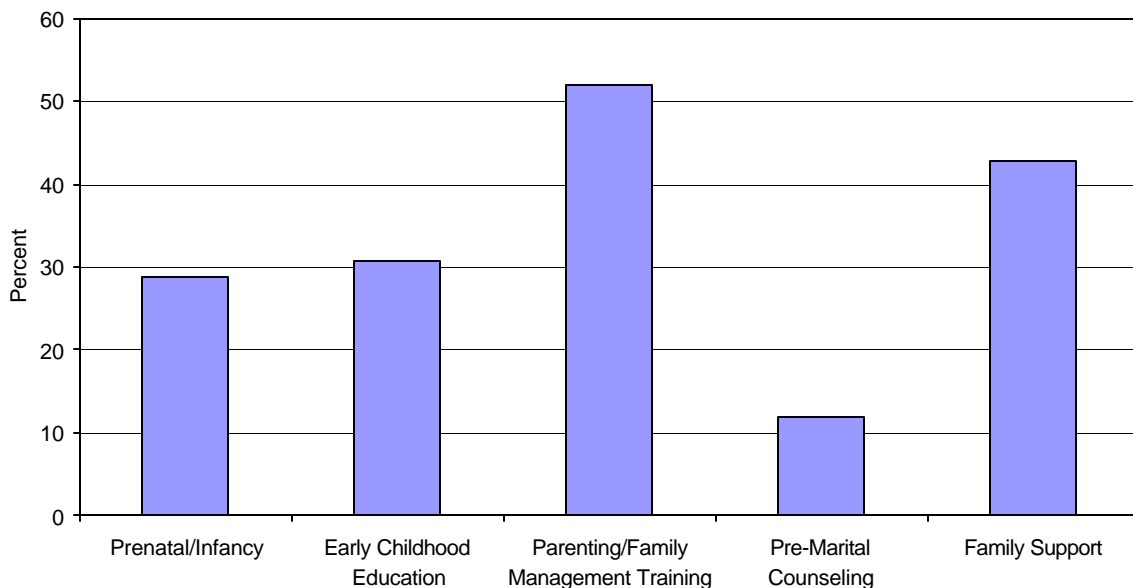
Exhibit 43 presents the findings for HPR III. More than 50 percent of respondents in HPR III reported that Parenting/Family Management Training (63.2%) and Family Support (56.6%) were services provided by their programs.

Exhibit 43. HPR III Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
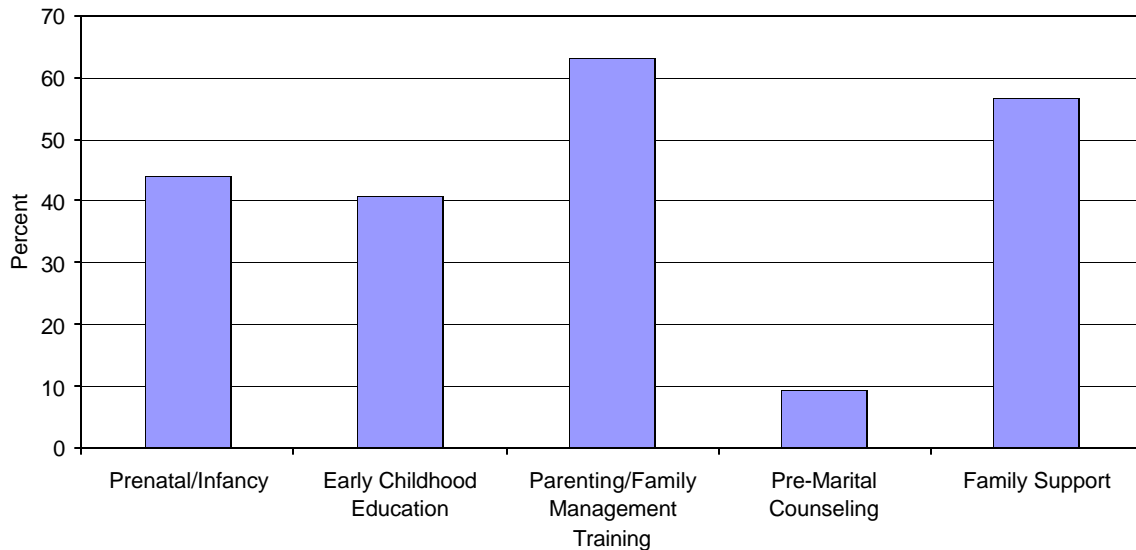
Exhibit 44 presents the findings for HPR IV. More than 50 percent of respondents in HPR IV reported that Parenting/Family Management Training (63.8%) and Family Support (60.0%) were services provided by their programs.

Exhibit 44. HPR IV Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
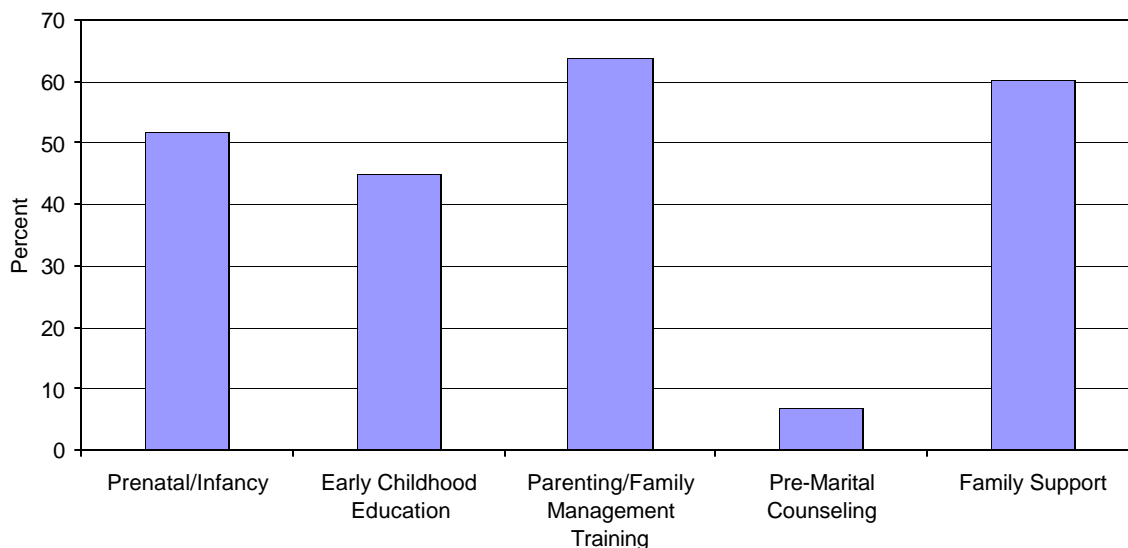
Exhibit 45 presents the findings for HPR V. The most common service provided by programs in the family domain was Parenting/Family Management Training (62.7%), followed by Family Support Services (53.1%) and Prenatal/Infancy (44.8%).

Exhibit 45. HPR V Programs/Services Provided by Prevention Programs—
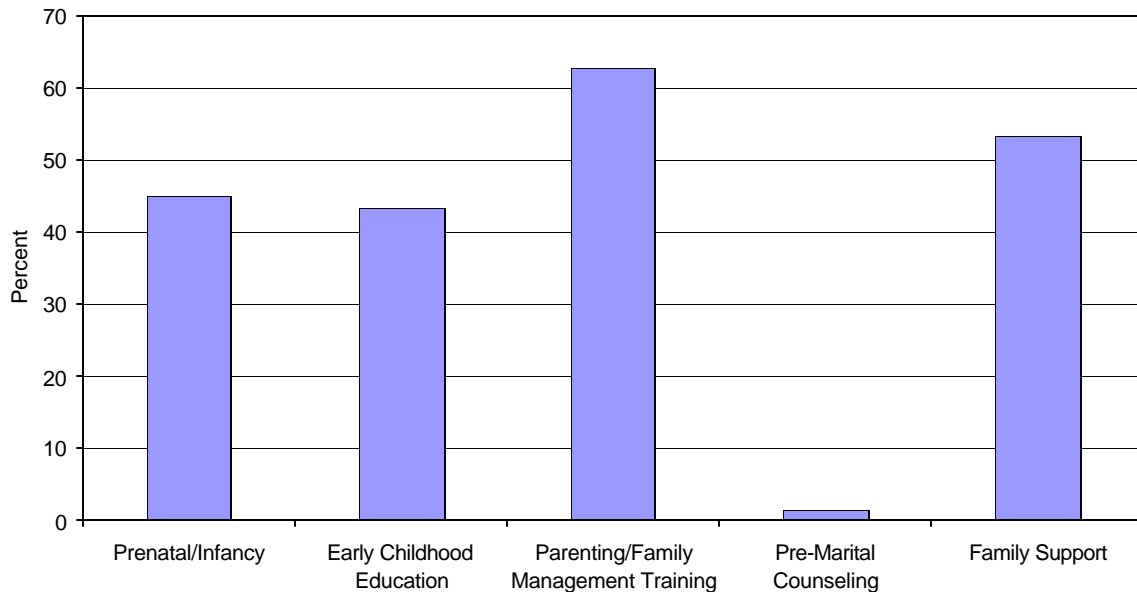
Family Domain: Phase II Respondents

School Domain

Exhibit 46 presents the Phase I findings on reported services in the school domain. The responses obtained from Phase I respondents revealed that the provision of Services Related to Organizational Change in School was the most commonly reported service (50%), followed by services related to Behavior Management and the Development of School Policies that Discourage Substance Use (42.1%).

Exhibit 46. Services Provided at the State and Local Level—School Domain: Phase I Respondents
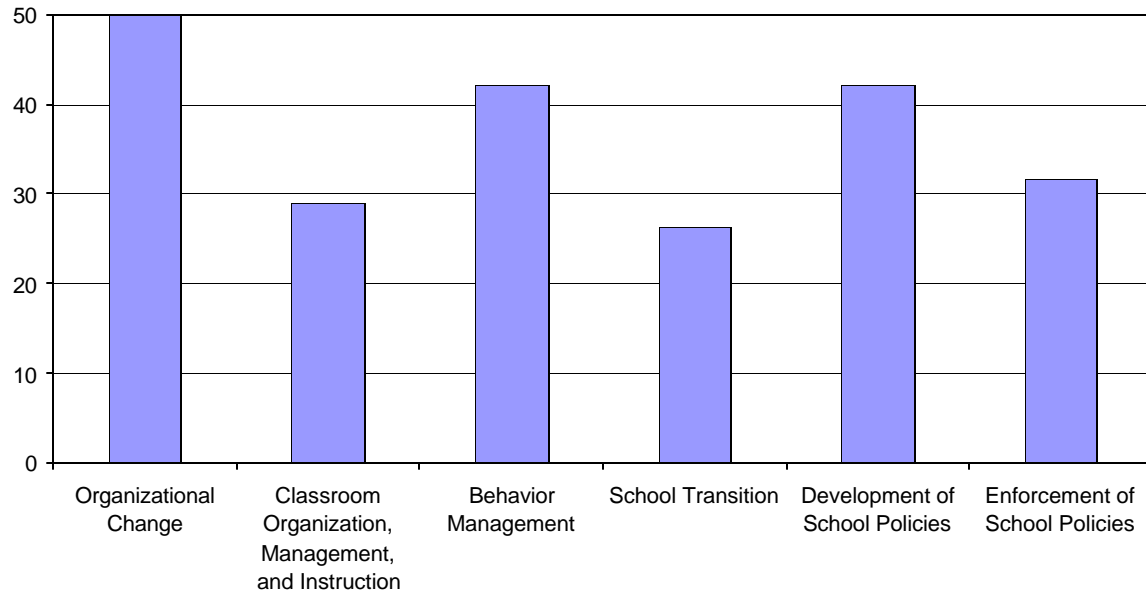
Exhibit 47 presents the findings for Phase II services provided by the Commonwealth within the school domain. The most commonly reported service in the school domain was Organizational Change in the Schools Through the Development of School-Community Partnerships or School Management Teams (43.1%), followed by Enforcement of School Policies that Discourage Substance Use (31.3%), and School Behavior Management (29.2%).

Exhibit 47. Commonwealth Programs/Services Provided by Prevention Programs—
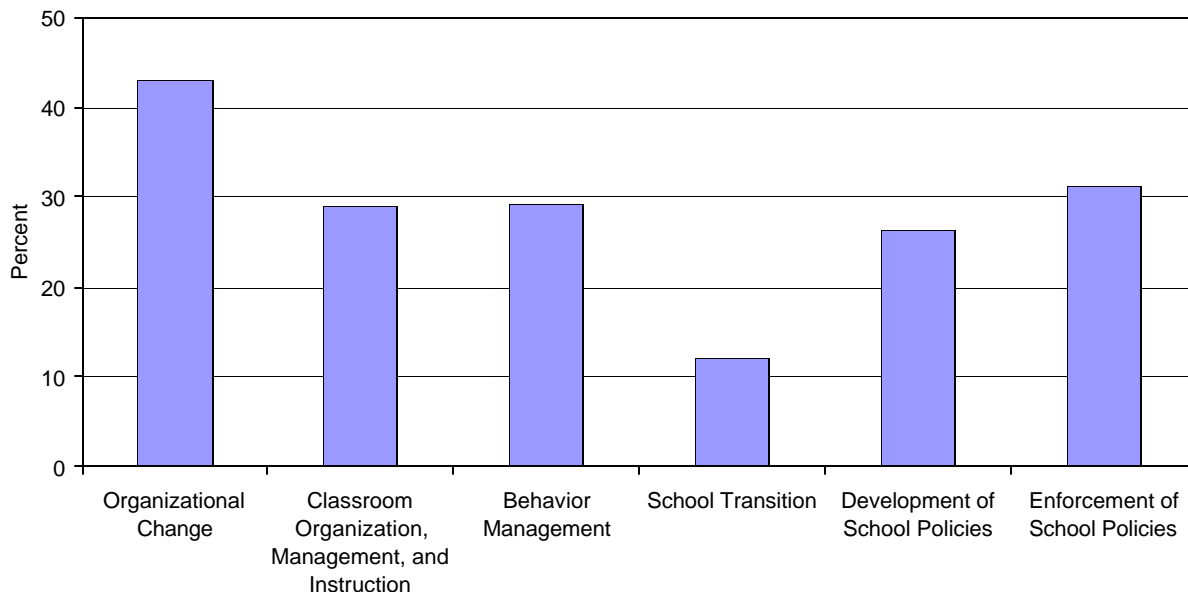
School Domain: Phase II Respondents

Exhibit 48 presents the findings for HPR I. The most common service in the school domain reported by respondents in HPR I was Organizational Change (41.3%), followed by Enforcement of School Policies (30.2%) and Development of School Policies (25.4%).
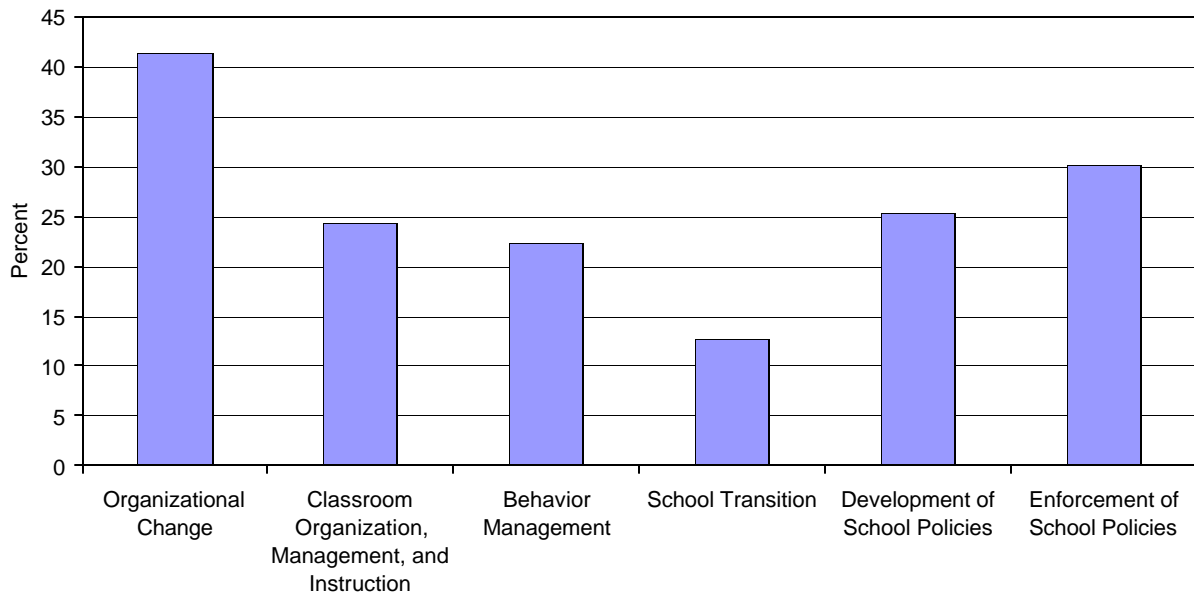
Exhibit 48. HPR I Programs/Services Provided by Prevention Programs—School Domain: Phase II Respondents

Exhibit 49 presents the findings for HPR II. The most common service provided by programs in HPR II was Organizational Change (34.7%), followed by Behavior Management (29.3%).
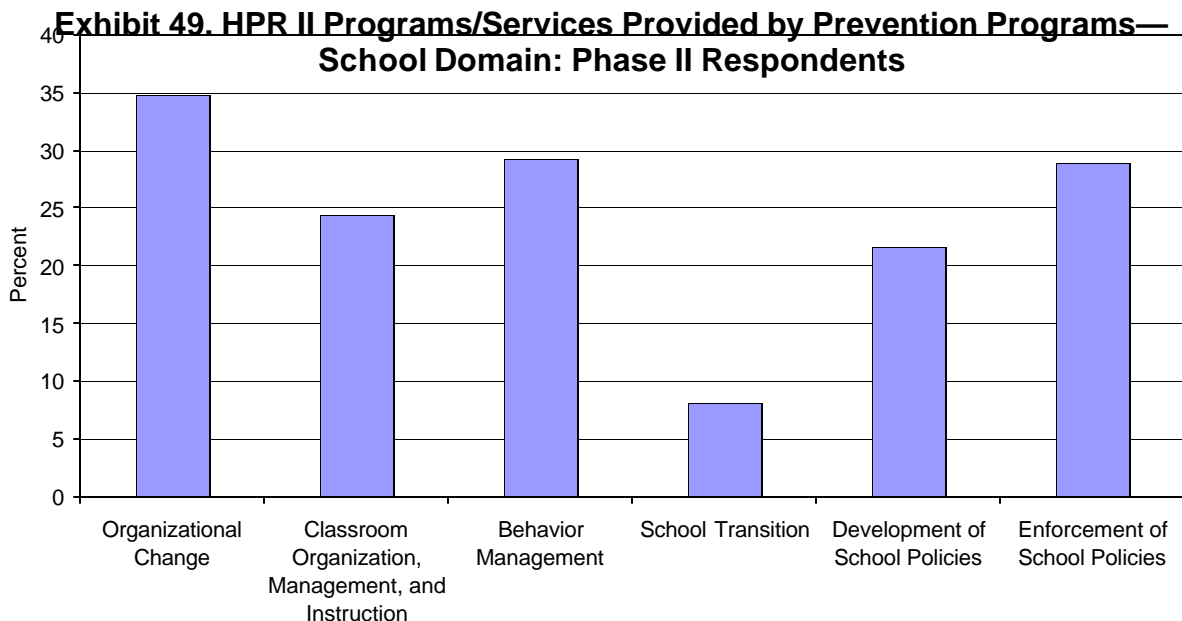
Exhibit 49. HPR II Programs/Services Provided by Prevention Programs—School Domain: Phase II Respondents

Exhibit 50 presents the findings for HPR III. The most common service within the school domain reported by respondents in HPR III was Organizational Change (41.9%), followed by Behavior Management (33.8%) and the Enforcement of School Policies Against ATOD Use (33.8%).

Exhibit 50. HPR III Programs/Services Provided by Prevention Programs—School Domain: Phase II Respondents
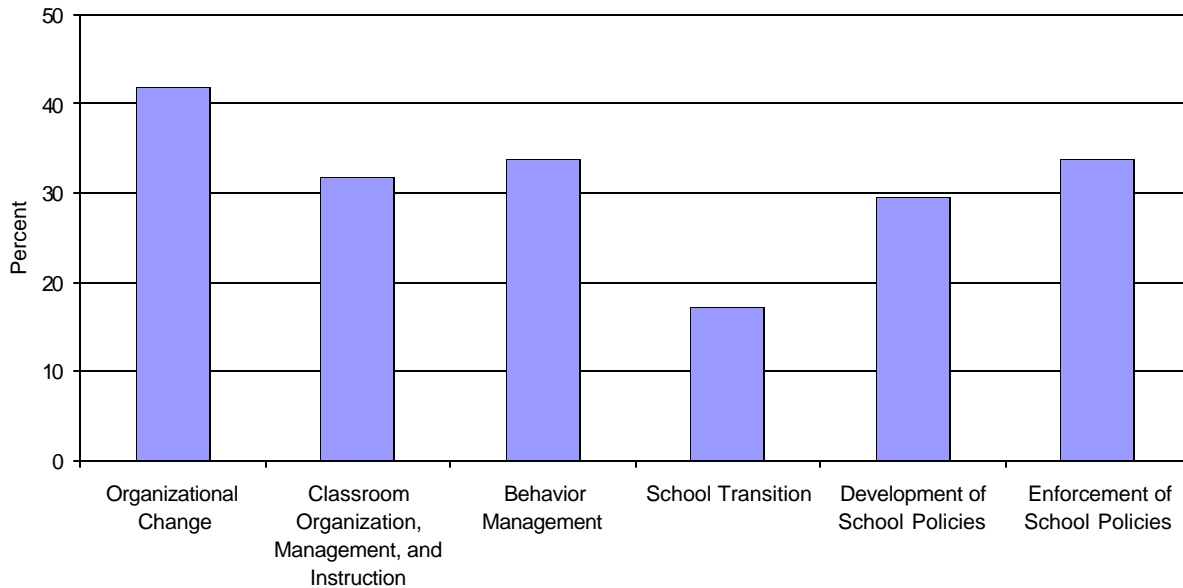
Exhibit 51 presents the findings for HPR IV. The most common service within the school domain reported by respondents in HPR IV was the Provision of Organizational Change Services (50%), followed by Classroom Organization, Management, and Instruction (37.3%).

Exhibit 51. HPR IV Programs/Services Provided by Prevention Programs—
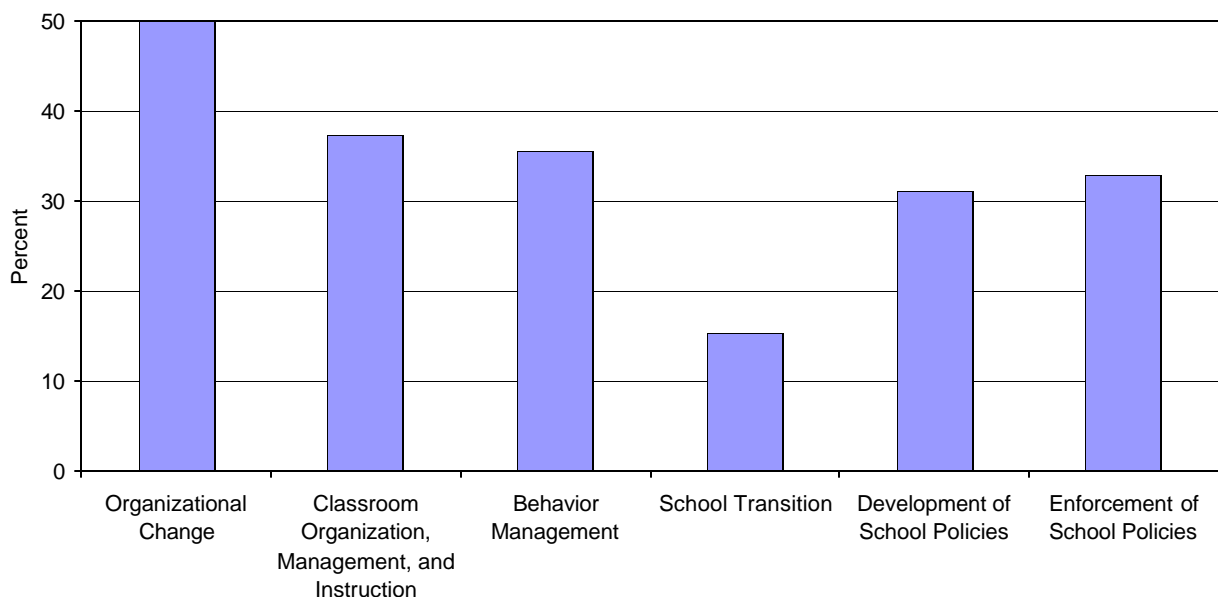
School Domain: Phase II Respondents

Exhibit 52 presents the findings for HPR V. The most common service within the school domain reported by respondents in HPR IV was the Provision Of Organizational Change Services (44.6%), followed by the Enforcement of School Policies (27.3%).

Exhibit 52. HPR V Programs/Services Provided by Prevention Programs—
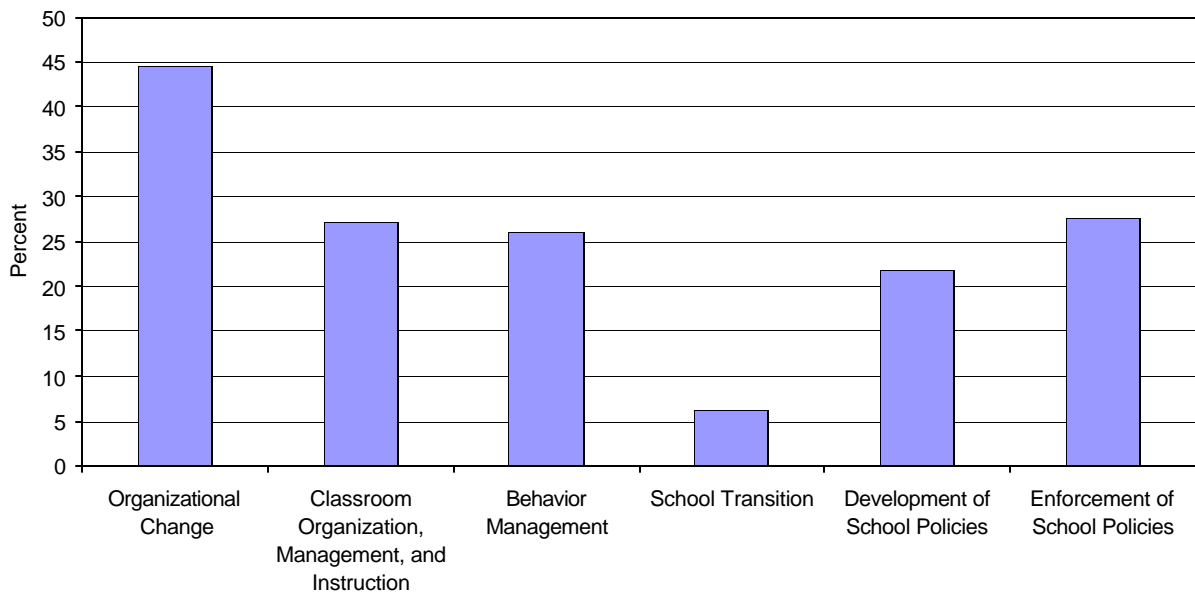
School Domain: Phase II Respondents

Community Domain

Exhibit 53 presents the Phase I findings on the provision of services in the community domain. The most common service reported by Phase I respondents was Information Dissemination (94.7%), followed by the Provision of Services Related to Community Development and Capacity Building (81.6%), and Engagement in Media Campaigns (78%).

Exhibit 53. Services Provided at the State and Local Level—Community Domain: Phase I Respondents
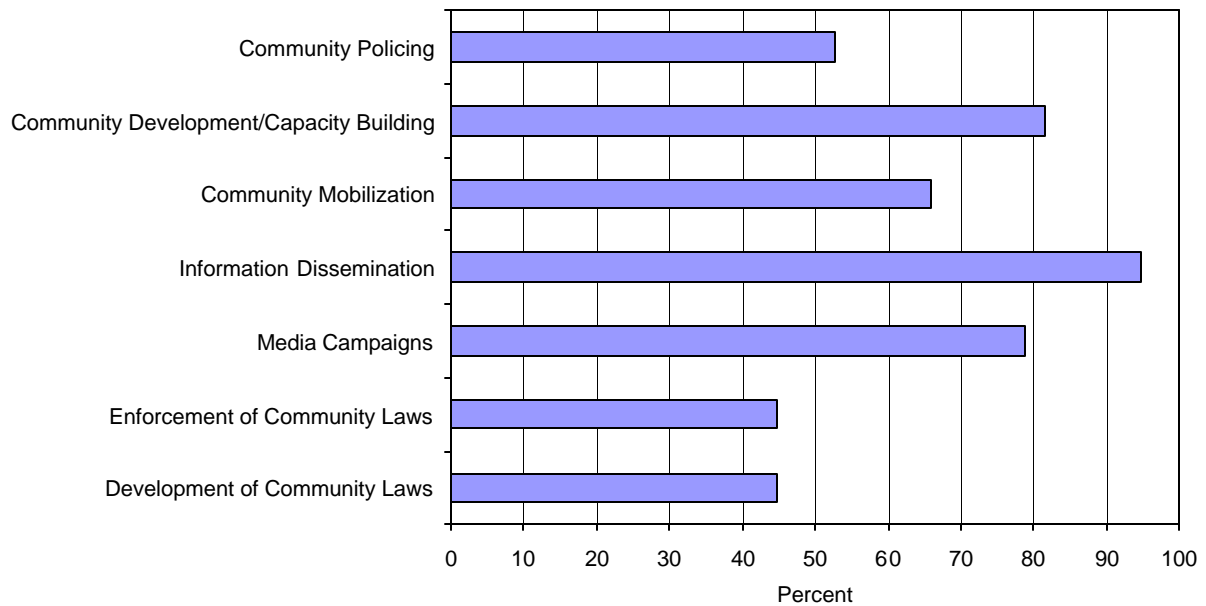
Exhibit 54 presents the Phase II findings for the Commonwealth on service provision in the community domain. In the Community Domain, more than 50 percent of respondents reported providing Information Dissemination (77.8%), Media Campaigns (56.7%), and Community Development/Capacity Building (52.1%) services.

Exhibit 54. Commonwealth Programs/Services Provided by Prevention Programs— Community Domain: Phase II Respondents
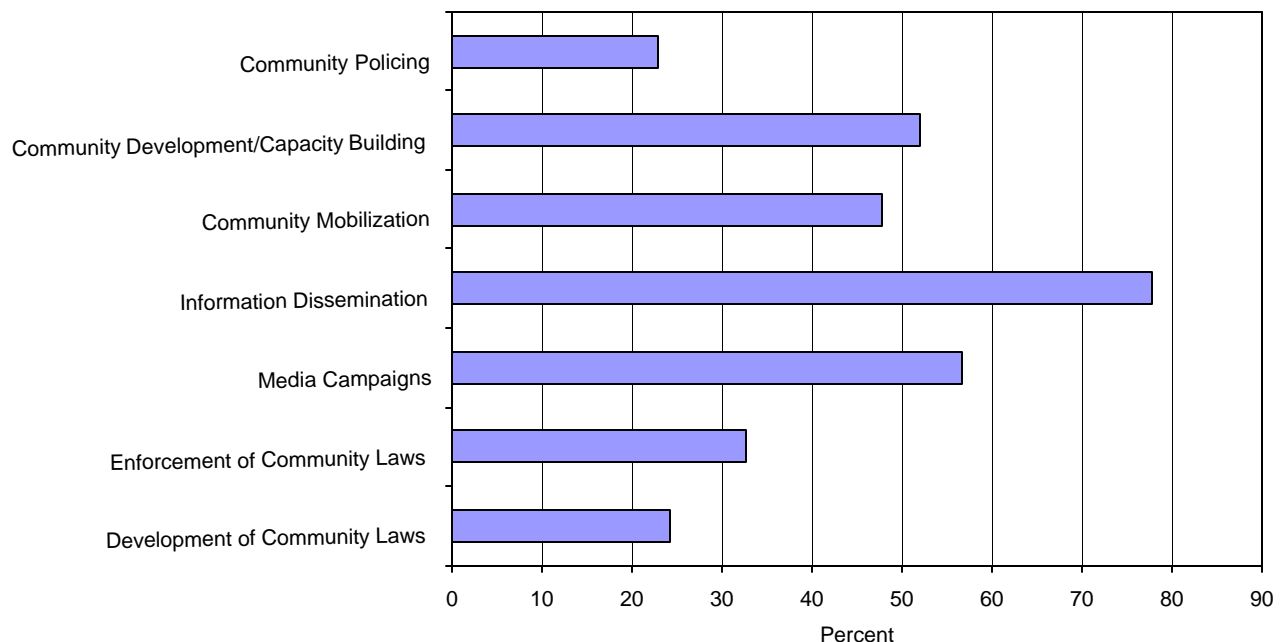
Exhibit 55 presents the findings for HPR I. Similar to the findings for the Commonwealth, the most commonly reported services within the community domain provided by programs in HPR I were Information Dissemination (77.1%) and Media Campaigns (61.9%).

Exhibit 55. HPR I Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
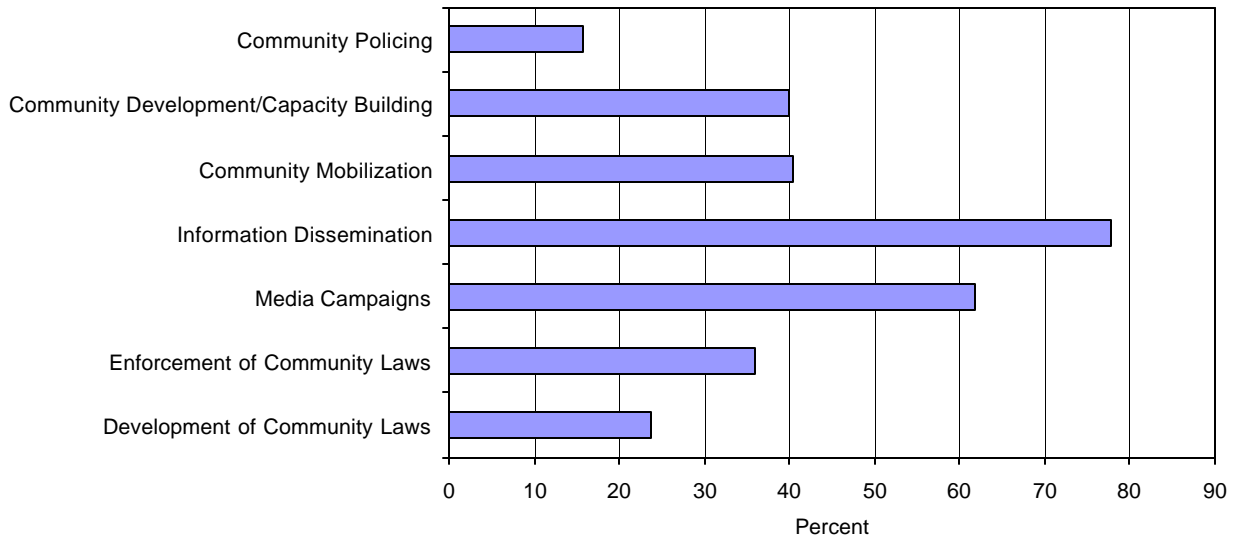
Exhibit 56 presents the findings for HPR II. The most common service within the community domain provided by programs in HPR II was Information Dissemination (77.3%), followed by Community Capacity Building (54.7%).

Exhibit 56. HPR II Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
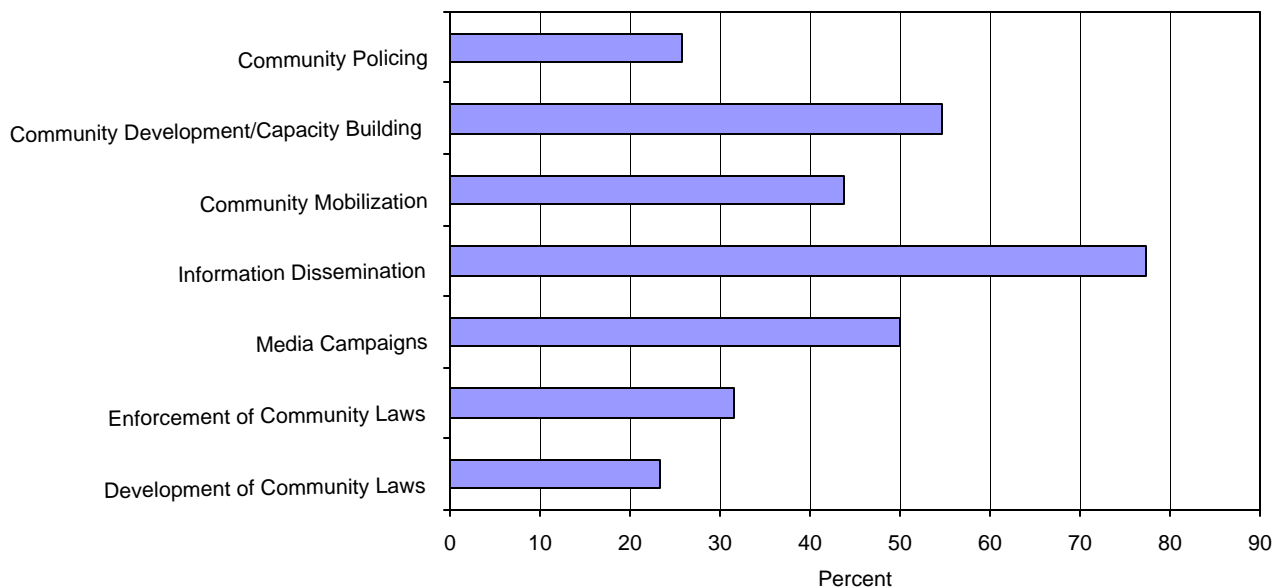
Exhibit 57 presents the findings for HPR III. The majority of respondents in HPR III reported that Information Dissemination (85.7%) and Media Campaigns (63.2%) were provided by their programs.

Exhibit 57. HPR III Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
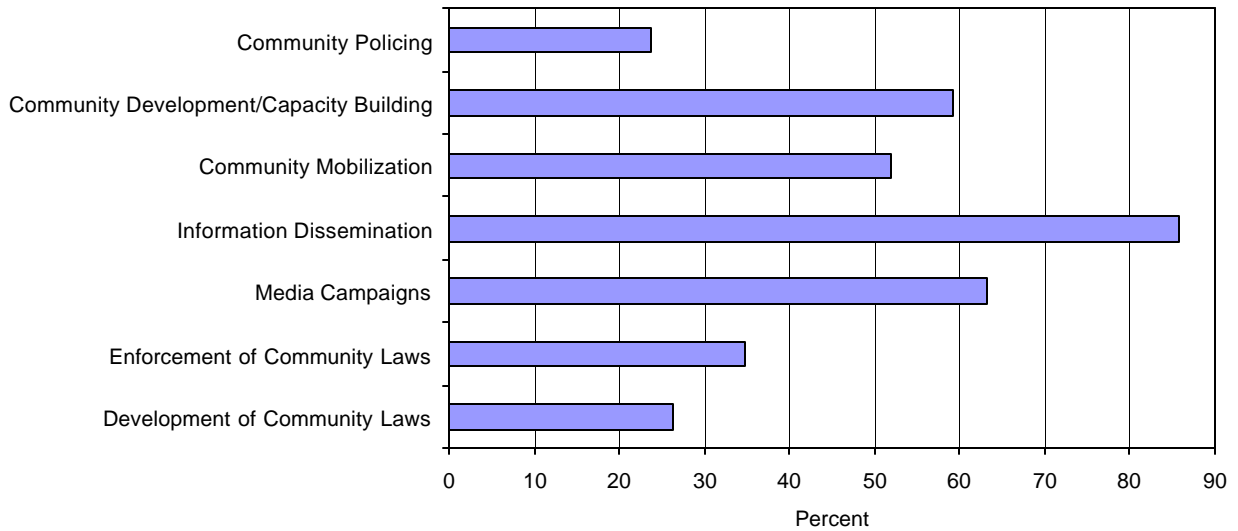
Exhibit 58 presents the findings for HPR IV. Eighty percent of respondents reported that their programs provided Information Dissemination services in HPR IV, followed by Media Campaigns (57.36%).

Exhibit 58. HPR IV Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
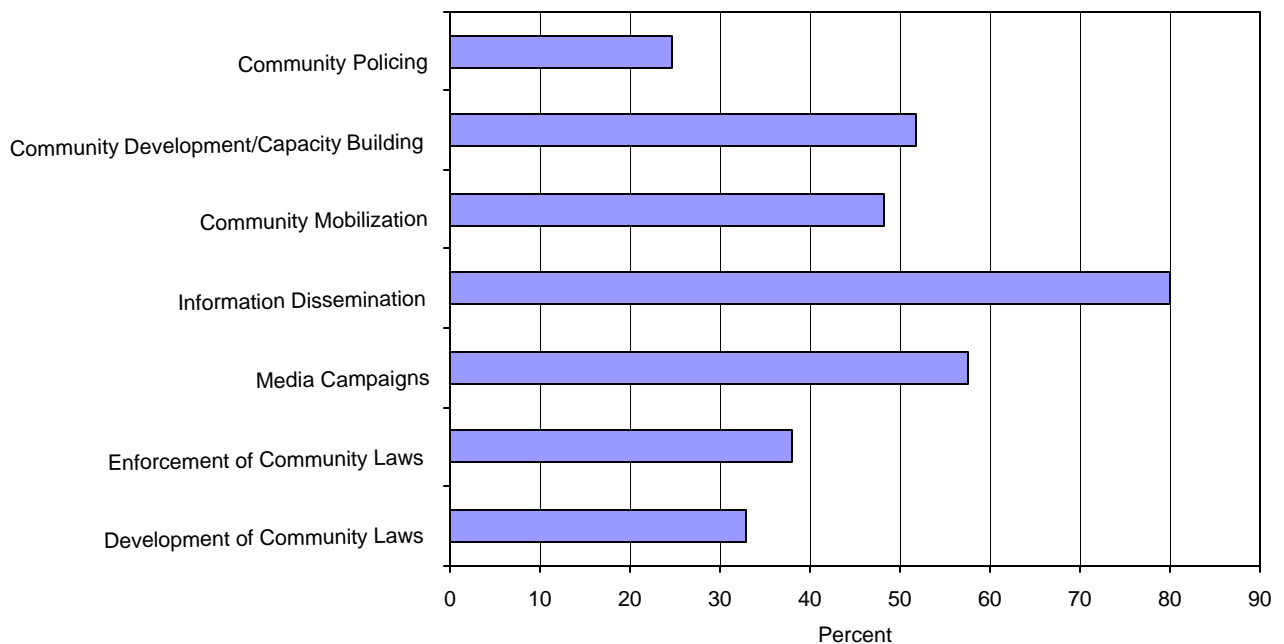
Exhibit 59 presents the findings for HPR V. Similar to the other HPRs, the most commonly reported services within the community domain in HPR V was Information Dissemination (71.2%) and Community Capacity Development (52.3%).

Exhibit 59. HPR V Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
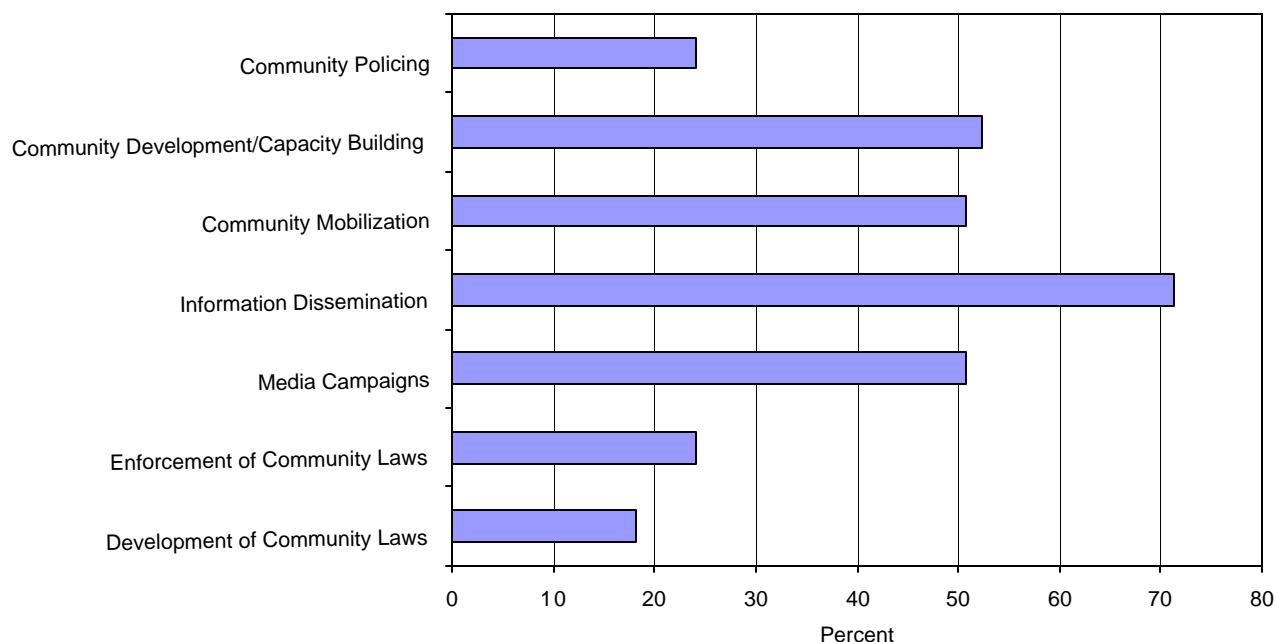
PREVENTION FUNDING

To obtain information on prevention funding at the Commonwealth level, Phase I and Phase II respondents were asked to report the annual budget for their office. In addition, Phase I respondents were asked to report funding sources and any changes in funding within the past year.

Budget

The average annual budget reported for prevention programs at the State level in the Commonwealth was $10,010,128. Annual budgets reported by Phase I respondents ranged from $10,000 to $64,000,000.

Exhibit 60 presents the findings on the average annual budget reported by Phase II respondents for prevention programs in the Commonwealth. The median reported budget for prevention programs in the Commonwealth was $145,000, with an average of $535, 851 and a range of $1,000 to $18,000,000.* HPRs II and V reported the highest median annual budget, $200,000. HPR II

---

* Annual budget information was provided by survey respondents. The respondents may not have been program administrators with day-to-day knowledge of program budgets. In some cases where unusually large budgets were reported (e.g. $18,000,000), the prevention programs were part of large multiservice county agencies, and respondents may have been reporting larger agency-wide budgets.

had an average annual budget of 1,176,757, a range of $18,000,000.HPR V had an average annual budget of 393,850, with a range of $3,000 to $2,950,000. The lowest reported median annual budget was in HPR I, $80,000, with an average annual budget of $182,7557, and a range of $1,000 to $2,251,510. The median annual budget in HPR III was $110,000, with an average at $338, 497 and a range of $5,000 to $4,754,281. In HPR IV, the median annual reported budget was $121,902, with an average of $460,032 and a range of $4,000 to 5,000,000.

Exhibit 60. Average Annual Program Budget: Phase II Respondents

	Average	Median	Range
Commonwealth	$535,851	$145,000	$1,000–$18,000,000
HPR I	$182,757	$80,000	$1,000–$2,251,510
HPR II	$1,176,575	$200,000	$1,500–$18,000,000
HPR III	$338,497	$110,000	$5,000–$4,754,281
HPR IV	$460,032	$121,902	$4,000–$5,000,000
HPR V	$393,850	$200,000	$3,000–$2,850,0000

*

TRAINING AND TECHNICAL ASSISTANCE PROVIDED TO THE FIELD

To obtain information on the types of training State-level agencies/organizations provided to the field, Phase I respondents were asked in an open-ended question to report the types of training they provided to the field.

Exhibit 61 presents the findings on the types of training provided to the field. The most common training reported by Phase I respondents (63.2%) was Training that was Specific to Each Particular Program (i.e., daycare providers may receive training on state code for daycare centers, information on how to care for children, etc.). The second most common training provided to the field was Program Management and Development (34.2%), followed by Grant Writing and Funding Opportunities (29%).

Exhibit 61. Types of Training Provided to the Field: Phase I Respondents
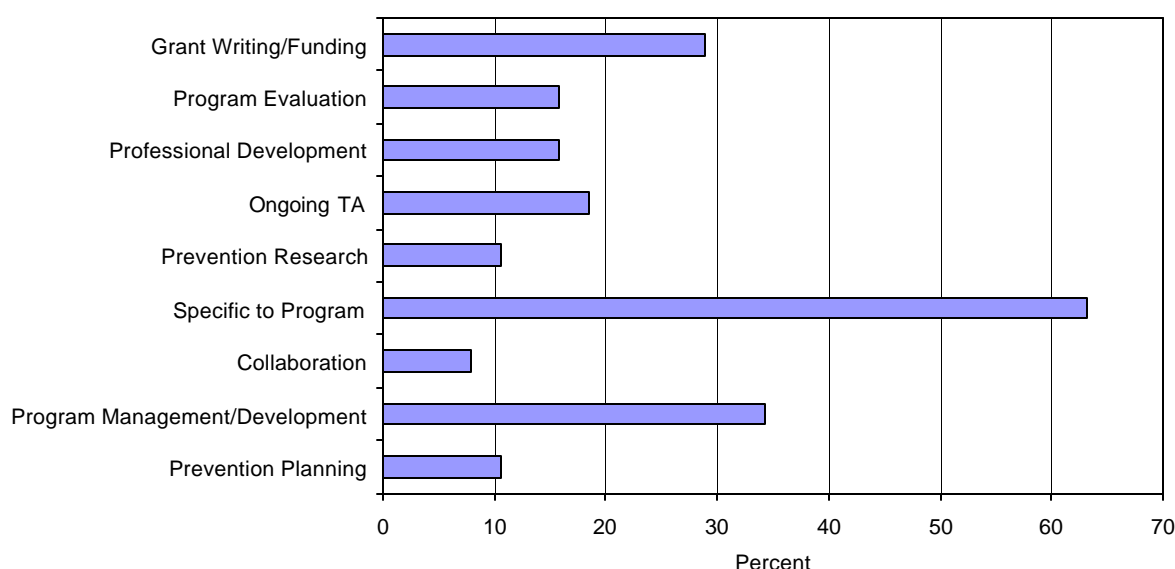
APPLICATION IN PREVENTION PLANNING

As previously discussed, approaches to ATOD prevention can be conceptualized as following a basic public health problem-response approach that includes (1) defining the problem, (2) identifying risk and protective factors, (3) identifying and implementing interventions, and (4) conducting program evaluations. Findings from the Virginia Community Resource Assessment can assist the Commonwealth and particularly local planning groups in Step Three of this process.

Step One–Defining the Problem

Findings from two other studies, the Virginia Community Youth Survey and the Virginia Social Indicator Study, can be used to assist state and local planners with defining problem behaviors in the Commonwealth and across all five HPRs.

Step Two–Identifying Risk and Protective Factors

Findings from the Virginia Community Youth Survey and the Virginia Social Indicator Study can be used in the second step in the prevention planning process to identify the risk factors known to increase the likelihood of ATOD problems and the protective factors that are known to buffer the influence of those risk factors.

Step Three–Identifying and Implementing Interventions

The third step in the planning process involves identifying interventions, (i.e., prevention programs that address the problems defined in Steps One and Two). This step involves the identification of available resources

targeting the specific risk and protective factors identified in a particular region (i.e., HPR) in Step Two.

Findings from the Virginia Community Resource Assessment can identify available resources that target specific risk factors. For instance, based on the results of the Community Resource Assessment we know that the main goals and objectives in the individual domain are the following:

- *Improving life/social skills;*

- *Strengthening attitudes against anti-social behavior;* and

- *Preventing antisocial behavior.*

These objectives are being met through the provision of life/social skills training, drug-free social activities, and mentoring services.

Assessing the match between these objectives and services and needs identified through the Community Youth Survey and Archival Social Indicator Study will allow prevention planners to determine if available resources are the most effective strategies in targeting identified needs. Gaps in services can be filled through the implementation of science-based programs that have been found to be the most effective in addressing specific risk and protective factors. These services can be identified through state or national prevention resources, such as DMHMRSAS, the Governor's Office for Substance Abuse Prevention, or CSAP, and implemented through local community organizations.

Information obtained from the Community Resource Assessment, together with the Archival Social Indicator and Community Youth Survey components of the Prevention Needs Assessment Studies, can assist the Commonwealth of Virginia in allocating prevention resources to close gaps in existing services, policies, and activities; buttress effective services, policies and activities; and assist planners and policymakers in prevention planning, resource allocation, evaluation activities, and policy development to help prevent ATOD use among Virginia's youth.

1. INTRODUCTION

Despite a downward trend in the prevalence of substance use, the use of alcohol, tobacco, and other drugs (ATOD) continues to be a serious health problem. ATOD use is a particular problem among youth. Findings from the 2000 Household Survey on Drug Abuse indicate that a large percentage of youth continue to use ATODs. In 2000, of youth ages 12 to 17, 13.4 percent reported the use of tobacco, 27.5 percent reported the use of alcohol, 18.7 percent reported binge drinking, and 9.7 percent reported the use of other drugs within the past month (Office of Applied Studies, SAMHSA, 2001a). An even more alarming statistic is the finding by the Substance Abuse and Mental Health Services Administration (SAMHSA) that the number of new initiates of alcohol consumption has jumped dramatically from approximately 1.7 million in the late 1980s to 3.4 million in 1998 (Office of Applied Studies, SAMHSA, 2001a). This finding underscores the importance of prevention.

The negative consequences of substance use on society have been well documented. The economic costs of ATOD use for taxpayers has been estimated at over $143 billion in treatment, health care, crime, and lost productivity (U.S. Department of Health and Human Services Press Office, 2002). In addition to the economic costs, ATOD use has been linked to a number of social problems. Researchers have consistently found a relationship with ATOD use and other problem behaviors. Youth who use ATODs are more likely to engage in violent behaviors (Office of Applied Studies, SAMHSA, 2001b), exhibit poor school performance, engage in risky sexual activity, be victimized, engage in delinquent behaviors, engage in suicidal behaviors and/or ideation, and run away from home (Office of Applied Studies, SAMHSA, 2000), compared to youth who do not use ATODs.

Additionally, alcohol has been linked to a number of youth fatalities. Each year, drug- and alcohol-related use kills more than 120,000 Americans. In the year 2000, a substantial number of traffic fatalities (29%) involving youth ages 16 to 20 were alcohol-related. Half of all youth who drown, a leading cause of death among youth, had been drinking prior to death. Finally, approximately 3 percent of college undergraduates will die from alcohol-related causes (Office of Applied Studies, SAMHSA, 2001). Extended use of ATODs has been linked to a number of health-related problems, including emphysema, cirrhosis of the liver, pancreatitis, stroke, certain forms of cancer, coronary heart disease, hepatitis B and C, and HIV (Hoyert et al., 2001; National Center for Chronic Disease Prevention and Health Promotion, 2001; Office of Applied Studies, SAMHSA, 2001a).

In direct response to the need for effective ATOD prevention programming, the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (VDMHMRSAS), through a contract with the Center for Substance Abuse Prevention (CSAP), conducted a Statewide Prevention Needs Assessment. One component of the needs assessment is this Community Resource Assessment. The purpose of the Community Resource Assessment is to document available prevention resources that target risk factors related to ATOD use. This report describes the

background, methodology, and findings of the Community Resource Assessment.

1.1 Background

In 1998, the VDMHMRSAS contracted with the CSAP to conduct a Statewide Prevention Needs Assessment. The Virginia Statewide Prevention Needs Assessment involves three studies: (1) a Community Youth Survey, (2) a Social Indicator Study, and (3) a Community Resource Assessment. The purpose of the needs assessment is to assist the Commonwealth and local decisionmakers with planning ATOD prevention strategies. A central purpose of the Community Resource Assessment is to ensure that this planning is based on data derived from reliable data collection procedures that are (1) consistent across the Commonwealth, (2) based on theory, and (3) comprehensive in scope.

Results from the Community Youth Survey and the Social Indicator Study will be utilized to identify salient risk factors, protective factors, and prevalence information. Data from the Social Indicator Study will be used in conjunction with data from the Community Youth Survey to identify and prioritize salient risk factors and problem behaviors in Virginia. As mentioned earlier, results from the Community Resource Assessment will identify available prevention resources in the Commonwealth of Virginia.

Data from the three studies will be integrated to provide prevention planners with information regarding the match between identified need and available resources. Prevention needs assessment data is essential to planning across all levels of the prevention system, from individual program planning to state-level strategy development. The main goal of the CSAP Prevention Needs Assessment is to provide prevention planners with current and accurate information that may be used to improve the match between service needs and available resources. Additionally, the results should be utilized by local and State prevention agencies to ensure that programs and services address identified risk factors and capitalize upon identified protective factors and resources.

In Virginia, ATOD use prevention efforts are planned and implemented by the community service boards (CSBs), which work closely with local health and human service providers, education professionals, the criminal justice system, the faith community, local community organizations, parents, and youth through community-based prevention planning groups. Each planning group conducts a local needs assessment to identify and prioritize risk indicators and performs a local resources assessment that includes services being offered or planned by the CSBs. Based on the needs and resource assessments, an annual plan is developed that specifies prevention objectives and links them to specific services to be offered.

Currently, Virginia has no systematic method utilized by State agencies to collect data on local resources. Recently, VDMHMRSAS began requiring CSBs to provide needs assessment information in their annual reports.

However, data collection methods vary across CSBs, resulting in vast differences in the types and detail of resource information available for the State. As a result, it has been difficult for Commonwealth-level policymakers and program planners to get a consistent picture of available resources targeting ATOD-related risk factors across the State.

The present study is an attempt to address concerns about the lack of prevention resource assessment information by deploying a standard set of sampling, data collection, and analysis procedures. The Community Resource Assessment is a single, standard measure of available resources across the Commonwealth.

1.1.1 *Background Literature*

The science behind ATOD prevention has evolved considerably, particularly since the late 1980s, when prevention programs typically incorporated linear cause-and-effect models that applied well-intentioned, but relatively simplistic strategies to target single domains. Examples include didactic programs to educate children about drugs or "just say 'no' " public awareness campaigns. With the benefit of more than a decade of concerted research that has explored more complex models and used longitudinal research to test etiological theories, it seems clear that ATOD use cannot be attributed to a single causal factor. Similarly, the prevention community has moved beyond single-cause theories to respond to an intricate play of risk and protective factors that heighten or attenuate risk for ATOD abuse. Increasingly, data are emerging from demonstration programs to support specific prevention strategies based on empirical evidence.

The "new public health," as described by Petersen and Lupton (1996) and others describes a focus on health that broadens the traditional biomedical model by envisioning health as a social entity that comprises perceptions and cultures (Petersen and Lupton, 1996). One implication of this new public health is to encourage community-based approaches that are centered not only on changes in the behavior of individuals but also on the interplay of changes in lifestyles, communities, and environments. In addition to ATOD prevention, this philosophy permeates other areas of public health, including child abuse and neglect, heart disease, and HIV infection (Diez Roux et al., 2001; Garbarino and Kostenly, 1992, 1997; World Health Organization and Canadian Public Health Association, 1996).

The theoretical and conceptual frameworks described in the following subsection are based broadly on the notion that the more risk factors a youth is exposed to, the more likely he or she is to have problems with ATOD use in adolescence. A reduction in the number of risk factors is associated with lower vulnerability to ATOD problems during the adolescent period (Newcomb and Felix-Ortiz, 1992). While research has demonstrated that exposure to risk factors heightens risk for abuse, it is apparent that some exposed children do not develop ATOD use problems. Researchers hypothesize that the risk-outcome pattern is interrupted for these children

because of factors that protect the child, such as secure family bonds, clear parental expectations, and academic success (Hawkins, 1992).

1.1.1.1   *Theoretical and Conceptual Frameworks*

A theory is a set of concepts that present a systematic view of events by specifying the relationships among variables. Theories are used to explain and/or predict events or situations. Health-related theories come from the social, behavioral, and biological sciences, and they borrow from such disciplines as anthropology and social psychology. It is now accepted in the field that effective prevention practice depends on the articulation of cogent theory, applying theory in practice, and evaluation based on the theoretical model. Conceptual frameworks are comprised of theories. Key theories that are relevant to the current state of ATOD prevention research are multi-level or ecological. That is, the idea that behavior affects and is affected at several levels by factors that include intra-personal or individual factors (e.g., knowledge and attitudes); interpersonal factors (e.g., roles and expectations of family and peers); and community factors (e.g., behavioral norms). Individual-level theories include Stages of Change and the Health Belief Model. The Stages of Change Model is often applied in tobacco cessation programs and refers to the individual's readiness to quit smoking. The Health Belief Model relates to the individual's negative or positive perception of a problem or behavior; for example, the individual's own ideas about the acceptability of drug use.

Social Learning Theory explains behavior as a three-way, dynamic, and reciprocal theory in which personal factors, environmental influences, and behavior continually interact. A basic premise is that people learn not only through their own experiences, but also by observing the actions of others and the results of those actions. Community Organization is a theory based on social network and support theory; it emphasizes active participation and the development of community resources to evaluate and solve health and social problems. Diffusion of Innovations Theory addresses how new ideas, products, and social practices spread within a society or from one society to another.

The Social Development Model, as operationalized by Catalano and Hawkins, (1996), provides an integrating conceptual framework to the Virginia Needs Assessment (Catalano and Hawkins, 1996; Social Development Research Group, 1994–2001). This model integrates social control and social learning theories with ecological models of child development to describe the antecedents of ATOD use and related problems and the resiliency factors that prevent such use within the context of a set of multiple societal domains. The social control and social learning theories specify the roles of parental and peer influences, social bonding, normative beliefs, and other factors predictive of children's behavior (Akers, 1977; Hirschi, 1969; Sutherland, 1956). Models such as Bronfenbrenner's ecological model of child development suggest the domains that play interacting roles in influencing individual development (Bronfenbrenner, 1979).

Based initially on longitudinal research with a cohort of 808 children in 1985, Catalano, Hawkins, and their colleagues began to compile findings suggesting that conditions in children's community, school, family, and peer environments in combination with the child's own psychological and biological traits, are common risk factors and that these risk factors are associated with such outcomes as ATOD abuse, delinquency, teen pregnancy, and school failure (Social Development Research Group, 1994–2001). In addition, there appear to be protective processes that shield children who are exposed to risk from negative outcomes. The Social Development Model focuses on two protective factors: (1) bonding to pro-social family, school, and peers; and (2) the existence of clear standards or norms for behavior (Social Development Research Group, no date). The processes that promote these protective factors include opportunities for the child's involvement in pro-social roles and for skills to be integrated into these roles, and consistent systems of recognition and reinforcement for pro-social involvement.

Bronfenbrenner's ecological model of human development provides a useful metaphor for understanding the Social Development Model. Bronfenbrenner used the metaphor of nested Russian dolls to explain his theory that forces impact on the developing child at levels that include the individual (microsystem), family-parent (mesosystem), community (exosystem), and cultural-political (macrosystem) (Bronfenbrenner, 1979). Exhibit 1-1 adapts this metaphor to describe the environment in which ATOD abuse occurs and incorporates CSAP findings about effective programs by domain (Bronfenbrenner, 1979; CSAP, 1999).

As shown in Exhibit 1-1, the concentric circles surrounding the individual can represent the sources of risk or the forces of protection. Each circle is nested within the other and together they form an interactive whole. The innermost circle represents the individual. Individual risk and protective factors tend to cluster around personality or psychosocial characteristics, attitudes, knowledge, and behaviors including (1) bonding to family, peers, and community members (Suedfeld, 1991); (2) psychological depression, conduct disorder, or other mental illness (Belfer, 1993); (3) academic achievement (Gillmore, Butler, Lohr, and Gilchrest, 1992); and (4) religiosity (Cochran, 1992; Greenwood, 1992). The influence of peers on adolescent ATOD use has been widely studied with the salient factors being use of drugs by peers (ONDCP, 1992); the norms established by a given peer group (Dielman, Butchart, and Shope, 1993); the quality of social interaction with peers (Bureau of Justice Statistics, 1992); and peer social pressure (Keefe, 1994).

Family factors may include a family history of ATOD abuse (Greenwood, 1992; Hawkins, Catalano, and Miller, 1992); and physical or sexual abuse (Arrowood, 1992). School-related factors are the youth's sense of connectedness to the school (CSAP, 1993), favorable attitudes of students toward drug use, availability of ATODs at school (CSAP, 1993); and rejection by school peers (Benard, 1990; Thomas and Hsiu, 1993).

Community risk factors include the availability of ATODs (Barea, Teichman, and Rahav, 1992; BJS, 1992; Chin, Lai, and Rosue, 1990–91; Laurs, 1990–91; ONDCP, 1992), sociocultural norms related to ATOD use (Cronin, 1993;

Gilbert, 1992; Pryor, 1992), poverty and economic conditions (Greenwood, 1992; Janlert and Hammarstrom, 1992; Johnson, 1991; NCC, 1991; Pryor, 1992), and violence and crime (Greenwood, 1992; NCC, 1991).

Exhibit 1-1
Ecological Model of Human Development
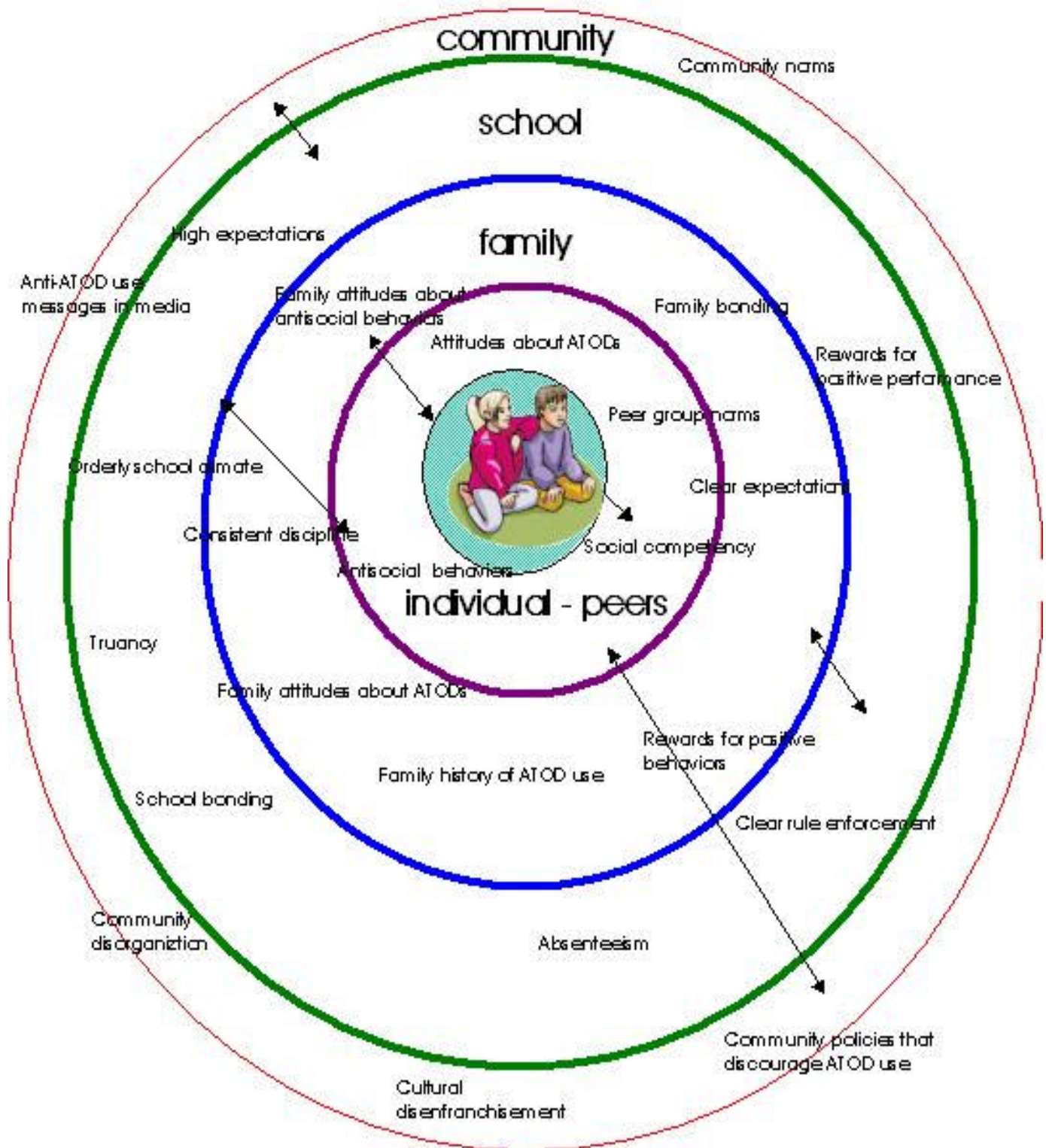
In Exhibit 1-1, the double-headed arrows represent transactional processes between and among the levels. For example, peer and community norms may influence individual behavior; similarly, family may influence the individual and also be influenced by such community variables as employment. A parent's own socioeconomic status or level of educational attainment may influence how empowered he or she feels to affect community social or political change. For example, a single woman with children who is reliant on subsidized housing may not feel that she can approach neighborhood association leaders or city officials to rid her neighborhood of drug dealers. Her lack of social status and reliance on public resources reduce her feelings of power and expectations for substantive change.

1.1.1.2   *Approaches to ATOD Prevention*

Although the science supporting prevention efforts has improved considerably and more programs are challenged by funders to implement evidence-based practices, there remain gaps in knowledge about the effectiveness of prevention efforts. The Institute of Medicine (IOM) (IOM, 2001) notes that most studies on program effectiveness have focused on school-based programs. Of the reviews and meta-analyses published in the past decade, which suggest that prevention programs are effective, these may be biased by the fact that published studies tend to review effective programs. Peer-reviewed journals may be less likely to publish studies reporting limited or no effects. Finally, the IOM notes that criteria for effectiveness require only a single significant finding from a group of measures (IOM, 2001).

The preponderance of approaches employed to prevent ATOD use among youth follow a basic public health problem–response approach that includes (1) defining the problem, (2) identifying risk and protective factors, (3) identifying and implementing interventions, and (4) program evaluation. The problem definition stage includes rigorous assessment of risk, protection, and outcomes at the community level with the goal of identifying areas exposed to the highest overall levels of aggregate risk and the lowest levels of protection. Once the community identifies and defines risk and protective factors, it must work collaboratively to prioritize risk and protective factors to design effective prevention strategies (Hawkins, 2001).

CSAP reports that effective prevention programs apply certain principles at the individual, peer, family, school, and community levels (CSAP National Center for the Advancement of Prevention, 2000). Within the peer/individual domain, attitudes against use appear to be necessary, but by themselves are not sufficient. Effective interventions focus on social and personal skills, as well as peer role models. At the family level, model programs emphasize family bonding and target children of ATOD-abusing parents. Within the school domain, effective CSAP programs have targeted teacher training and have established mentoring programs and community-level interventions that target norms and involve multiple agencies (CSAP, 2001; CSAP National Center for the Advancement of Prevention, 2000). CSAP reviews its prevention grantee programs annually and selects model programs based on

specific criteria. Information about these programs is available in CSAP publications and on the CSAP Web site.

Because social development prevention strategies are based on community-wide indicators, interventions at each of the domain levels are designed to address specific risk and protective factors across a r ange of developmental periods dependent upon identified and prioritized community needs. At the peer/individual level, a community may choose to address risks associated with peer group use of ATODs. Strategies that target younger children may include parent training and classroom curricula to promote social competence. For older children, a program may implement peer mentoring in high schools. At the family level, programs may incorporate prevention programs during the prenatal period to counteract problems associated with a family history of ATOD use and antisocial behaviors. Because academic failure during the late elementary years has been shown to predict ATOD abuse later in life, programs may employ prenatal and infancy programs, early childhood education, and parent education for the youngest age groups and youth employment and education for high school-age youth. To counteract community norms favorable to ATOD use and antisocial behaviors, prevention programs may use classroom curricula and encourage the development of new community norms regarding ATOD use (Social Development Research Group, 1994–2001).

1.2   Community Resource Assessment

The Community Resource Assessment was designed to measure available resources that target 26 risk factors believed to increase youth's risk of ATOD use and 10 protective factors believed to buffer youth against exposure to risk. These risk and protective factors are based on research described in the literature reviewed above, are consistent with risk and protective factors measured by other CSAP Needs Assessment state studies, and include risk/protective factors that were identified by Virginia DMHMRSAS prevention research staff as relevant for Virginia.

An initial step in the design of a resource assessment is to prioritize the types of resources that are the focus of investigation. This is important because of the large number and wide range of resources that could potentially be included in the analysis. To increase feasibility and usefulness, it is imperative that the scope of the study be defined.

First, the types of resources that will be the focus of investigation must be identified. The types of prevention resources available within a state may be quite vast, ranging from information dissemination to actual services that target ATOD use. Arthur, Shavel, Tremper, Hawkins, and Hansen (1997) have identified three types of resources: (1) assets, (2) infrastructure, and (3) programs. Assets are resources that may be used indirectly to reduce the likelihood of ATOD use. Examples include (l) funding, (2) organizations, and (3) data. Infrastructure includes laws and policies, delivery systems, training and technical assistance. The third resource, programs, are services and/or activities that target the prevention of problem behaviors. Arthur et al.,

(1997), argue that a comprehensive resource assessment must include an analysis of all three types of resources described above. In order to achieve this, the current study will attempt to collect information on all three types of resources. However, note that prevention resource information will be organized by the type of risk and protective factors targeted, not by the type of resource utilized.

The types of prevention resources that may be investigated must be narrowed. The working definition of prevention resources for the current study is "any effort that attempts to attenuate risk factors or increase protective factors within a community." As previously discussed, the theoretical framework guiding the Virginia Statewide Needs Assessment family of studies is Catalano and Hawkins' (1996) Theory of Social development. Based on a review of the literature, Hawkins, Catalano, and Miller (1992) describe a number of risk factors related to ATOD use. These factors may be characterized in four domains: peer/individual, family, school, and community. The overall purpose of the resource assessment is to determine if available resources match community needs. To achieve this goal, information on the availability of resources that target the needs of interest must be collected. Therefore, the current study will only target risk- and protective factor focused prevention resources. The Community Resource Assessment will collect and organize information on resources that target risk and protective factors measured in the Youth Survey and Social Indicators Study. The risk and protective factors fall within each of the domains and are described below.

1.2.1 *Peer/Individual Domain Risk Factors:*

- *Rebelliousness*—Rejecting authority, tradition, or accepted ways of behaving (e.g., do not feel a sense of belonging to society);

- *Early initiation of drug use*—Beginning to use ATODs at a young age (e.g., youth who use alcohol before the age of 15 are four times more likely to develop alcohol dependence than those who begin drinking at age 20 and older, and each additional year of delayed drinking onset reduces the probability of alcohol dependence by 14 percent (Grant and Dawson, 1997);

- *Early initiation of antisocial behavior*—Beginning to engage in acts that harm other individuals, groups, or the community in which one lives at an early age (e.g., attacking someone with the idea of seriously hurting them);

- *Impulsiveness*—Acting without forethought or consideration of the consequences;

- *Favorable attitudes toward antisocial behavior*—Having a low sense of social responsibility (i.e., believing that acts which harm other individuals, groups or the community at large [e.g., theft or picking a fight with someone] are acceptable);

- *Favorable attitudes toward drug use*—Believing that ATOD use is acceptable;

- *Perceived risks of drug use*—Believing that people who use ATODs have little risk of harming themselves (physically or in other ways);

- *Interaction with antisocial peers*—Being friends with peers who exhibit antisocial behaviors such as selling illegal drugs or stealing;

- *Friends' use of drugs*—Having close friends who use ATODs;

- *Sensation seeking*—Seeking out novel, exciting stimuli with little regard for potential consequence (e.g., doing something dangerous because someone dares them to or doing what feels good without regard for consequence);

- *Rewards for antisocial involvement*—Engaging in acts that threaten or harm others for real or perceived rewards (e.g., believing one would be seen as "cool" if they used drugs or carried a handgun); and

- *Gang involvement*—Being in (or having close friends in) a group that defines itself as a gang.

1.2.2 *Peer/Individual Domain Protective Factors*

- *Religiosity*—Attending religious services or activities;

- *Social skills*—Dexterity in interacting with others (e.g., good communication skills or ability to appropriately use humor to defuse a stressful situation); and

- *Belief in the moral order*—Believing in a moral purpose to one's activities (e.g., it is not okay to cheat at school or take something without asking even if you believe you won't get caught).

1.2.3 *Family Domain Risk Factors*

- *Poor family management*—Little monitoring of children's behavior or no clear rules/expectations for behavior;

- *High family conflict*—Frequently engaging in verbal abuse, serious arguments between family members, and unresolved family arguments;

- *Family history of antisocial behavior*—Having family members (both adults and siblings) who have engaged in antisocial behaviors such as selling illegal drugs or stealing;

- *Parental attitudes favorable to drug use*—Believing that parents do not think their child's use of ATODs is wrong; and

- *Parental attitudes favorable to antisocial behavior*—Believing that parents do not think it is wrong for their child to engage in behaviors such as stealing, fighting, or vandalism.

1.2.4 *Family Domain Protective Factors*

- *Attachment*—Having a sense of belonging and closeness to family members;

- *Opportunities for pro-social involvement*—Believing that youth are valued participants and contributors in the family (e.g., parents solicit input from children when making family decisions that affect them); and

- *Rewards for pro-social involvement*—Reinforcement by family members for doing a good job (e.g., parents notice and praise children when they do something well).

1.2.5 *School Domain Risk Factors*

- *Academic failure*—Grades are lower than most other students in their class; and

- *Low commitment to school*—School is not an important part of the youth's life, includes high rates of school dropouts (e.g., believing that school work is not meaningful or interesting and the youth has very little connection to or involvement in school life).

1.2.6 *School Domain Protective Factors*

- *Opportunities for involvement*—Youth are engaged in school through efforts to enlist their input in decisions (e.g., they are given the opportunity to help decide class activities and rules) and are offered opportunities to participate in extracurricular activities such as sports and clubs; and

- *Rewards for pro-social involvement*—Youth receive notice and praise for doing well or working hard in academics or other school activities.

1.2.7 *Community Domain Risk Factors*

- *Low neighborhood attachment*—Having little feeling of connection or commitment to the neighborhood or personal investment in staying in the neighborhood;

- *High community disorganization*—Perceiving a lack of community cohesion that may be evidenced by such things as crime and/or drug selling, empty or abandoned buildings, or a lack of natural surveillance of public places;

- *Transitions and mobility*—Reporting high rates of movement from one community or home to another or from one school to another;

- *Laws and norms favorable to drugs*—Believing that community norms or expectations that youth ATOD use is unavoidable or even acceptable (e.g., adults serving alcohol at high school graduation parties) or lack of enforcement of laws regulating use of ATODs (e.g., underage drinking), or laws that may be viewed as permissiveness or give "mixed messages" to youth (e.g., decriminalization of marijuana);

- *Availability of drugs*—Believing that they (youth) could obtain alcohol, tobacco products, or illegal drugs such as marijuana with relative ease, includes rates of alcohol sales, alcohol outlets, and tobacco outlets; and

- *Perceived availability of handguns*—Believing that they (youth) could obtain a handgun if they wanted to get one; and

- *Extreme economic and social deprivation*—Involves high rates of unemployment, Free and Reduced Lunch participants, TANF participants, Food Stamp recipients, adults without a high school diploma, and single parent family households.

1.2.8 *Community Domain Protective Factors*

- *Opportunities for pro-social involvement*—Youth activities (e.g., sports teams or service clubs) are available in the community; and

- *Rewards for pro-social involvement*—Youth are noticed, encouraged to do their best, and praised by neighbors and other community members when they do something well.

The assessment of existing resources and their relationship to identified prevention needs is a critical first step in identifying unmet needs (Arthur et al., 1997; Fiorentine, 1993; McKnight and Kretzman, 1990). The assessment of resources can assist prevention planners and providers to examine the match between existing prevention policies and programs and identified prevention needs; allocate prevention resources to close gaps in existing policies and programs; and improve prevention accountability and track costs. Information that is key to prevention planning includes the types of services that exist to address identified needs, patterns of service utilization, service accessibility and affordability, and the availability of other resources designed to support and complement existing community prevention resources (Goldsmith et al., 1998; Guyer et al., 1984; Harlow and Turner, 1993; Uehara et al., 1994). When the above information is provided with geographic and demographic information regarding who is served and where the service occurs, states, sub-state areas, and local communities can make better decisions about where to allocate available resources.

Analysis of this information can provide detailed descriptions of community prevention capabilities. Once the community resource information is integrated with the youth survey and social indicator data, State prevention specialists will be better able to identify resource strengths and weaknesses (i.e., gaps) and to reexamine existing resource allocation plans.

The following chapters (1) describe the Community Resource Assessment methodology; (2) present findings of available resources that target risk and protective factors related to ATOD use for urban versus rural areas, and for individual health planning regions (HPRs); and (3) summarize the findings and present implications for prevention planning.

2. METHODOLOGY

The Community Resource Assessment study was designed to collect information on available resources at the State and local level targeted at the prevention of ATOD use. Information from the Community Resource Assessment can provide detailed descriptions of community prevention capabilities. Data were collected to measure (1) prevention needs, (2) staff capabilities, (3) program objectives, (4) budget and funding, (5) program strategies, (6) program participant demographics, (7) program objectives, (8) evaluation and collaboration activities, and (9) barriers to service. This chapter describes the study sample, procedure, and the data analysis process.

2.1 Study Sample

The target population for the Community Resource Assessment included prevention specialists familiar with State-, regional-, and local-level prevention resources in the Commonwealth of Virginia. The target population consisted of employees from a variety of prevention agencies, including State and local government, nonprofit, universities and colleges, and religious organizations. Two sample populations participated in the Community Resource Assessment: Phase I participants and Phase II participants.

2.1.1 *Phase I*

Phase I participants consisted of 38 prevention professionals with knowledge of prevention resources at the State level. Two methods were employed to generate a list of potential Phase I respondents. First, the Community Resource Assessment Advisory Committee generated an initial list of potential respondents. Second, a review of State agency/organization Web sites was used to supplement the initial list. Forty potential respondents were contacted. Of these, two participants (due to limited time) declined participation, resulting in a total of 38 participants.

Phase I participants were State-level prevention administrators from the following agencies:

- Department of Mental Health, Mental Retardation, and Substance Abuse Services;
- Department of Alcoholic Beverage Control;
- Department of Criminal Justice Services;
- Department of Education;
- Department of Health;
- Department of Juvenile Justice Services;
- Department of Social Services;
- Housing Development Authority;
- University of Richmond;

- Virginia Technical University;
- Virginia Commonwealth University;
- United Way of America; and
- Virginia Catholic Charities.

2.1.2   *Phase II*

Phase II participants consisted of 338 prevention directors who managed the delivery of prevention services within the 10 CSB geographic regions that participated in the Community Youth Survey component of the Virginia Statewide Prevention Needs Assessment Studies. Phase II participants were selected from the following CSBs and associated localities:

- Valley CSB: August County and Staunton City;
- Rappahannock-area CSB: Caroline County and Stafford County;
- Prince William CSB: Prince William County;
- Arlington CSB: Arlington County;
- Blue Ridge CSB: Botetourt County and Roanoke County;
- Panning District 1 CSB: Scott County and Wise County;
- Crossroads CSB: Amelia County and Cumberland County;
- District 19 CSB: Dinwiddie County and Petersburg City;
- Middle Peninsula/Northern Neck CSB: Mathews County and Richmond County; and
- Hampton/Newport News CSB: Hampton City and Newport News City (although Hampton/Newport News declined participation in the youth survey, this area was not excluded from the CRA).

Three methods were employed to generate a list of potential Phase II respondents. An initial list of Phase II contacts was developed by Phase I respondents. Phase I respondents were sent a letter requesting contact information on local program directors in the selected localities (i.e., those localities that participated in the Community Youth Survey; see Appendix A). This method resulted in the identification of 133 potential respondents. The initial list was supplemented through a search of the Internet to identify programs and program directors in the selected localities. The second method resulted in the identification of another 367 potential Phase II respondents. The third method employed the inclusion of a contact sheet with the Community Resource Assessment survey when it was mailed. Phase II respondents were asked to identify other program directors providing services within their area, resulting in a list of 319 potential Phase II respondents.

Forty-three duplicate contacts were identified and removed from the list of potential Phase II respondents, resulting in a total of 776. Four hundred and forty potential Phase II participants responded to our survey requests. Thus,

the response rate for the surveys was 57 percent. However, of the 440 responses, 95 respondents indicated that the goals of their programs were not applicable for the purpose of the current survey. This resulted in a total of 345 completed and applicable surveys. Of the 345 completed surveys, 7 were discarded because they were not prevention programs: 3 were aftercare programs for youth committed to the Department of Juvenile Justice's correctional centers, 3 were substance abuse treatment programs, and 1 was a summer camp. Therefore, a total of 338 returned and completed surveys were applicable for the present study: 68 surveys from HPR I, 77 surveys from HPR II, 77 surveys from HPR III, 61 surveys from HPR IV, and 67 surveys from HPR V (eight of the surveys provided services in more than one HPR).

Phase II participants were local program directors/managers of prevention programs from the following agencies/organizations:

- American Heart Association;
- American Lung Association;
- American Red Cross;
- Big Brothers/Big Sisters;
- Boys and Girls Clubs of America;
- CASA;
- Cooperative Extensions;
- Department of Health (local);
- Department of Housing;
- Department of Juvenile Justice Court Service Units;
- Department of Juvenile Justice Offices on Youth;
- Department of Mental Health, Mental Retardation, and Substance Abuse Services Community Services Boards;
- Department of Social Services (local);
- Family preservation services;
- Health clinics/family planning clinics (e.g., planned parenthood, etc.);
- Local coalitions, councils, centers, and foundations;
- Local police departments and sheriffs' offices;
- Public libraries;
- Public schools;
- Religious organizations (e.g., Catholic Charities, ministries, etc.);
- Salvation Army;
- United Way; and
- YMCA.

2.2   Instruments

The data collection instruments utilized in Phase I and Phase II were based on CSAP's Core Community Resource Assessment Survey (see Appendices B and C, respectively). The Community Resource Assessment Survey was designed by a CSAP workgroup comprised of researchers and State representatives involved in the Statewide Prevention Needs Assessment process.

2.2.1   *Phase I*

The Core Community Resource Assessment survey, designed specifically for collecting information on service delivery (Phase II), was modified for Phase I respondents. Phase I respondents have a global knowledge regarding State- and regional-level assets and infrastructure. In order to capture this knowledge, questions were added to the survey to collect information on funding streams, training and technical assistance, laws and policies that influence prevention programming, statewide prevention needs, and agencies' goals and objectives. Additionally, questions regarding specific program processes were excluded, as State-level respondents may not have detailed knowledge regarding this type of information. The Phase I interviews consisted of 122 questions divided into the following categories:

- Prevention needs;
- Agency/department's main goals or objectives;
- Services provided;
- Staff credentials/training;
- Budget/funding;
- Collaboration activities;
- Data/evaluation; and
- Barriers to service delivery.

Exhibit 2-1 provides a description of the questions that pertain to each category.

Exhibit 2-1. Survey Categories and Associated Questions

Category	Question
Prevention needs	What do you think are the greatest prevention needs in the Commonwealth?
Goals/objectives	What do you think your office's main goals and objectives are?

Category	Question
Services provided	What types of training/technical assistance does your office provide to the field?
	Does your office engage in the following youth-focused programs?
	• Afterschool Recreation;
	• Drug-Free Activities;
	• Adventure-Based Programs;
	• Intergenerational programs;
	• Mentoring;
	• Career/Job Skills;
	• Community Service;
	• Peer Leadership;
	• Life/Social Skills Training;
	• Drop-In Centers;
	• Tutoring;
	• Support Groups; or
	• Community Action Groups.
	Does your office engage in the following family-focused programs?
	• Prenatal/Infancy;
	• Early Childhood Education;
	• Parent/Family Management;
	• PreMarital Counseling; or
	• Family Support.
	Does your office engage in the following school-focused programs?
	• Organizational Change;
	• Classroom Organization;
	• Management and Instructional Practices;
	• School Behavior Management;
	• School Transition;
	• Development of School Policies That Discourage ATOD Use; or
	• Enforcement of School Policies That Discourage ATOD Use.
	Does your office engage in the following community-focused programs?
	• Development of Community Laws and Policies That Discourage ATOD Use;
	• Enforcement of Community Laws And Policies That Discourage ATOD Use;
	• Media Campaigns;
	• Information Dissemination;
	• Community Mobilization;
	• Community Development/Capacity Building; or
	• Assistance With Community Policing Programs.
Staff credentials/training	How many years have you worked in current position?
	How many years have you worked in prevention?
	For each of the following types of training, please indicate if your staff has received *none, a little, some* or *a lot*:
	• Asset building;
	• Leadership development;
	• Coalition building;
	• Program implementation;
	• Fundraising;
	• Program monitoring;
	• Risk/protective factor framework;
	• Cultural awareness; and
	• Effective research-based prevention approaches.
	How many full-time staff are employed in your agency?
	How many full-time staff are employed in your office?

Category	Question
	How many volunteer staff in your agency are devoted to prevention?
	How many volunteer staff in your office are devoted to prevention?
Budget/funding	What is your annual budget?
	Does your office receive funding from the following services: State agency, Federal grants or contracts, local/municipal funds, program fees, or foundations?
	Please indicate which of the following best fits changes in funding that have taken place in your office in the last year: • Doubled or more than doubled; • Increased somewhat; • Stayed about the same; • Decreased somewhat; or • Was cut in half or more than half.
Collaboration	With which of the following agencies does your office participate in joint planning: • Schools; • Youth service bureaus; • Prevention councils; • Police or juvenile justice departments; • Religious organizations; • Substance abuse councils; • Recreation departments; • Health departments; • Social service departments; or • Private nonprofit agencies, private businesses?
Data/evaluation	From the following list of data types, please indicate if you collect this type of data, use it for planning, or if you provide the data to others for planning purposes: • Prevention needs; • Drug use and crime; • Clearinghouse; • Research-based prevention strategies; • Populations served; • Program descriptions; • Program monitoring; or • Program evaluation. If you collect data for program effectiveness, please indicate which of the following best matches your data collection strategy: • Collect data only before program begins; • Collect data only immediately after the program ends; • Compare differences in data collected before the program begins and immediately after the program ends; • Conduct long-term followup; • Collect anecdotal evidence; • Collect data multiple times during the program; or • Other.
Barriers to service	Please indicate for each of the following items if the issue is a *significant barrier*, a *moderate barrier*, a *minor barrier*, or *not a barrier*: • Lack of program slots; • Limited hours of operation; • Insufficient staff; • Staff turnover; • Program criteria too restrictive; • Lack of public awareness;

Category	Question
	• Cultural or language differences; • Lack of transportation; • Service fee not affordable; • Perceived social stigma; • Lack of community interest; • Program participant drop-out; • Waiting list; • Insufficient collaboration with schools; • Insufficient collaboration with community organizations; • Program location unsafe; or • Lack of childcare facilities.

2.2.2 *Phase II*

The Phase II CRA instrument included all Core CSAP Resource Assessment Survey questions. In addition, questions were added to collect more specific information concerning evaluation procedures, prevention needs, and program goals. The Phase II survey was developed in Teleform so that completed surveys could be scanned electronically. The mail survey is an eight-page document with 171 questions that can be divided into the following categories:

- Prevention needs in locality;

- Program goals and objectives;

- Regions served;

- Programs/services;

- Program intensity;

- Population demographics;

- Staffing/qualifications;

- Budget;

- Data and evaluation; and

- Barriers to service delivery.

Exhibit 2-2 presents the categories and associated questions.

Exhibit 2-2. Phase II Survey Categories and Associated Questions

Category	Question
Prevention needs	What do you think are the greatest prevention needs in the Commonwealth?
Goals/objectives	What do you think are your program's main focus or objectives? To what extent does your program address the following objectives (*a main focus, not a main focus but addressed, not addressed*):
Goals/objectives *(continued)*	• Program objectives in peer/individual domain:

Category	Question

	– *Prevent ATOD use;*
	    – *Strengthen perceptions about harmful effects of ATOD use;*
	    – *Strengthen attitudes against ATOD use;*
	    – *Prevent antisocial behaviors;*
	    – *Strengthen attitudes against antisocial behavior;*
	    – *Increase involvement in positive activities;*
	    – *Increase involvement in religious activities;*
	    – *Increase positive relationships with adults;*
	    – *Reduce involvement in delinquent peer groups and drug-using peer groups;*
	    – *Reduce symptoms of depression;*
	    – *Reduce rebelliousness;*
	    – *Improve social skills;*
	    – *Increase awareness of peer norms opposed to ATOD use; and*
	    – *Provide alternative activities.*
	• Program objectives in family domain:
	    – *Reduce ATOD use in family;*
	    – *Improve family management skills;*
	    – *Improve family communication skills;*
	    – *Change parental attitudes toward youth ATOD use;*
	    – *Increase positive family involvement opportunities;*
	    – *Improve rewards for family involvement; and*
	    – *Reduce marital conflict.*
	• Program objectives in school domain:
	    – *Establish ATOD policies;*
	    – *Improve academic skills;*
	    – *Improve student commitment;*
	    – *Increase opportunities for positive participation;*
	    – *Increase rewards for positive participation;*
	    – *Increase opportunities for positive participation in classroom; and*
	    – *Increase parental involvement.*
	• Program objectives in community domain:
	    – *Adjustment to new home or school;*
	    – *Reduce access to ATODs;*
	    – *Increase opportunities for positive involvement;*
	    – *Increase reward for positive involvement;*
	    – *Develop laws that restrict ATOD use;*
	    – *Strengthen norms against ATOD use;*
	    – *Improve neighborhood safety;*
	    – *Organization; and*
	    – *Sense of community.*

Regions served	What geographical region does your program cover? What is the street address where this program delivers its services?
Services provided	Does your program engage in the following youth-focused services? • After-School Recreation; • Drug-Free Activities; • Adventure-Based Programs; • Intergenerational Programs; • Mentoring; • Career/Job Skills; • Community Service; • Peer Leadership; • Life/Social Skills Training; • Drop-In Centers; • Tutoring; • Support Groups; or
Services provided *(continued)*	• Community Action Groups.

Category	Question
	Does your program engage in the following family-focused services? • Prenatal/Infancy; • Early Childhood Education; • Parent/Family Management; • Premarital Counseling; or • Family Support. Does your program engage in the following school-focused services? • Organizational Change; • Classroom Organization; • Management and Instructional Practices; • School Behavior Management; • School Transition; • Development of School Policies That Discourage ATOD Use; or • Enforcement of School Policies That Discourage ATOD Use. Does your program engage in the following community-focused services? • Development of Community Laws and Policies That Discourage ATOD Use; • Enforcement of Community Laws and Policies That Discourage ATOD Use; • Media Campaigns; • Information Dissemination; • Community Mobilization; • Community Development/Capacity Building; or • Assistance with Community Policing Programs.
Program intensity	How many weeks did this program operate in the past 12 months? On average, how long does each session last? On average how often does each session take place: • Days per week • Days per month

Population demographics	How many participants took part in your program in the last 12 months?
	Please identify the primary populations that your program served:
	• Primary population in community domain:
	  – Criminally involved adults;
	  – Economically disadvantaged groups;
	  – Civic groups;
	  – Collations;
	  – Gays/lesbians;
	  – Government;
	  – Immigrants/refugees;
	  – Law enforcement/military;
	  – Migrant workers;
	  – Older adults;
	  – People using substances;
	  – People with disabilities;
	  – Abused peopled;
	  – Pregnant women;
	  – Religious groups;
	  – Rural/isolated populations;
	  – Urban/inner-city populations; or
	  – Women of childbearing age.
	• Primary population in peer/individual domain:
	  – Children of substance abuser;
	  – Delinquent youth;
	  – Foster children;
	  – Homeless/runaway;

Population demographics	– Economically disadvantaged youth;

Category	Question

(continued)	– School dropouts;
	 – Pregnant teens; or
	 – Students at risk of dropping out of school.
	 • Primary population in family domain:
	   – Parents/families.
	 • Primary population in school domain:
	   – Preschool students;
	   – Elementary school students;
	   – Middle/junior high students;
	   – High school students; or
	   – College students.
	 • Primary population in business:
	   – Business and industry;
	   – Health care professionals;
	   – Managed care organizations; or
	   – Teachers/administrators/counselors.
	
	 Please estimate the percentage of program participants in each of the following age groups:
	
	 • 0–4;
	 • 5–11;
	 • 12–14;
	 • 15–17;
	 • 18–20;
	 • 21–24;
	 • 25–44;
	 • 45–66;
	 • 65 and older.
	
	 Please estimate the percentage of participants that were:
	
	 • Male;
	 • Female.
	
	 Please estimate the percentage of participants that were:
	
	 • White;
	 • Black;
	 • Asian;
	 • Hispanic;
	 • Multiracial; or
	 • Native American.

Staff credentials/training	How many years have you worked in your current position? How many years have you worked in prevention? Do you have any special training in prevention? If yes, what type? Please indicate the number of prevention staff and the average number of hours per week they worked in your program during the last 12 months: • Number of paid full-time staff (adults and youth) • Number of paid part-time staff (adults and youth) • Number of volunteers staff (adults and youth) • Average hours full-time staff work • Average hours part-time staff work • Average hours volunteers work
Budget/funding	Please estimate the annual budget for this program for the past year.

Category	Question
Collaboration	Does your program co-sponsor events or activities with other community organizations?
	Does your program participate in joint planning with other community organizations?
	Does your program share funding or staff with other community organizations?
Data/evaluation	Does this program use data for any of the following purposes:
	• Does not use data;
	• Reporting to key stakeholders;
	• Meet funding requirements;
	• Program planning;
	• Community mobilization;
	• Process evaluation;
	• Grant or contract proposals;
	• Outcome evaluations; or
	• Needs assessment?
	Is the evaluation conducted by in-house staff or is it contracted out?
	When are the data collected?
	• Before the program begins;
	• Just after the program has ended;
	• During the program;
	• Some time;
	• Other;
	• Don't know.
Barriers to service	Please indicate the extent to which each of the following is a barrier to effective delivery of prevention services:
	• Lack of program slots;
	• Limited hours of operation;
	• Insufficient staff;
	• Staff turnover;
	• Program criteria too restrictive;
	• Lack of public awareness;
	• Cultural or language differences;
	• Lack of transportation;
	• Service fee not affordable;
	• Perceived social stigma;
	• Lack of community interest;
	• Program participant drop-out;
	• Waiting list;
	• Insufficient collaboration with schools;
	• Insufficient collaboration with community organizations;
	• Program location unsafe; and
	• Lack of childcare facilities.

2.3   Procedure

Phase I data collection involved personal interviews with 38 state-level prevention administrators. Phase II data collection involved the administration of surveys with local program directors. Detailed descriptions of both phases are provided below.

2.3.1 *Phase I*

Personal interviews of Phase I respondents focused on collecting information regarding State-level prevention resources. Letters that informed the respondents of the purpose of the interview and a copy of the interview instrument were sent to 40 potential Phase I participants. The letter also indicated that the participant would be contacted by phone to schedule a personal interview. The contact letter was followed by a telephone call to reiterate the purpose of the study, the confidentiality of the study, and to schedule a convenient time for the interview. Thirty-eight of the 40 individuals contacted agreed to participate (95% response rate). These individuals were sent a letter reminding them of the time and date of their interview and a copy of the interview questions for them to review prior to the interview. Copies of the letters sent to Phase I participants are included in Appendix D.

One day prior to the interview, respondents were contacted by phone to confirm the interview time. All interviews were conducted at the respondents' place of business. Immediately prior to the interview, the interviewer restated the purpose of the CRA and asked the interviewee for a brief description of his/her job. Subsequently, all interview questions were read from a form and answers were recorded by hand. The personal interviews ranged from 1 to 2 hours in length. Following the personal interview, the respondents were sent a letter thanking them for their participation. The Community Needs Assessment coordinator who conducted all 38 interviews is a highly experienced interviewer with the skills necessary for conducting accurate, valid, and unbiased interviews with diverse populations. Her familiarity with the study goals and Phase I respondent agencies precluded the need for additional training specific to this study.

2.3.2 *Phase II*

Phase II data collection involved mail surveys sent to Phase II respondents. The Phase II surveys focused on collecting information specific to program processes. As previously stated, mail surveys were sent to 776 prevention providers working within the same CSB sites as those who participated in the Community Youth Survey. Two methods were implemented to increase the response rate for Phase II data collection.

First, the total design method was utilized (Dillman, 1978). Dillman (1978) found that multiple contacts with respondents during data collection increase response rates. Contacts with Phase II participants included introductory letters sent prior to the survey; a cover letter included with the survey that explained the survey's purpose and procedures for its completion; and three followup requests to return the survey: the final followup request included another copy of the Phase II survey. Copies of the letters sent to Phase II participants are included in Appendix E.

The second method was based on previous research, which has found relatively high response rates (more than 80%) when the mail surveys have important benefits/consequences for respondents (Herberlein and

Baumgartner, 1978). Based on this study, a paragraph that stressed the importance of the survey, its relevance, and potential benefits to the respondent was included in the survey cover letter.

Thus, initial letters were sent to Phase II participants describing the purpose of the CRA and soliciting their participation. Subsequently, a cover letter, survey, and self-addressed stamped envelopes were sent to Phase II participants. The cover letter reiterated the purpose of the CRA and provided a deadline for receipt of the surveys. Approximately 2 weeks following the survey deadline, respondents who had not completed and returned the survey were sent a followup letter. The followup letter reiterated the purpose of the CRA and reminded respondents to complete and return the survey. Approximately 1 month later, a second followup letter was sent to respondents who had not completed and returned the survey. Approximately 1 month following the second followup letter, a third followup letter and a copy of the survey was mailed to respondents who had not completed and returned the survey.

2.4   Data Analysis

Methods for entering, cleaning, and analyzing the survey data are provided in the following sections.

2.4.1   *Data Entry*

Data from Phase I interviews were hand-entered in a Microsoft Access database. Data for Phase II surveys were initially scanned utilizing Teleform software. However, due to problems with the Teleform software package, only 23 surveys were scannable. Therefore, 322 of the Phase II surveys were hand-entered in a Microsoft Access database.

2.4.2   *Data Cleaning*

Data cleaning efforts included:

- Random check of entered data with original source;
- Identification of missing values;
- Identification of out-of-range values; and
- Checks for logical inconsistencies (e.g., percentages for male and female participants equals 100).

An initial examination of the data was conducted through a random check of data entered in the database with the original source. Because the error ratio was relatively low (less than .05%), a complete check of all surveys was not conducted. A second data cleaning method was an examination of the data for out-of-range values. Out-of-range values were identified utilizing SPSS. Out-of-range values were corrected by checks made to the original data source to

determine if the value was a data entry/importation error. Inaccurate data were corrected in the database.

Next, an examination of the data was conducted to identify missing values. Following the identification of missing values, checks were made to the original data source to determine if the missing value was a data entry error. Inaccurate data were corrected in the database.

Finally, appropriate checks were made for logical inconsistencies. Errors were checked with the original data source. Any errors that were due to a respondent's inconsistent responses (e.g., response of 51% female and 51% male) were discarded. Inaccurate data were corrected in the database.

In addition, because the survey is a pilot instrument, checks were made to determine if respondents understood or could answer all survey questions. Checks included an examination of the data to determine (1) if a large percentage of respondents did not answer the question (i.e., a large percentage of the data were missing) and (2) if there were logical inconsistencies in responses to a question (i.e., if respondents were asked to select only one category, but a larger percentage of respondents selected more than one). Based on this examination, six questions were discarded from further analyses.

Four staffing questions from the Phase I survey were discarded. To gather information on the percentage of prevention staff in each agency, respondents were asked to indicate the number of full-time and volunteer staff working in the agency and in their specific office. However, the majority (76%) of respondents did not know how many full-time staff or volunteers worked in the agency as a whole. In addition, two questions asked respondents to indicate the number of paid staff that were devoted to prevention in the agency and in their office. In most cases, prevention resources were located in the respondent's office; therefore, neither of these questions were applicable: 84 percent of respondents did not answer the question regarding the number of staff in the agency devoted to prevention, and more than 90 percent of respondents indicated that all their staff in their office were devoted to prevention. Thus, these two questions were also discarded. Similarly, one question pertained to the percentage of respondents' budget devoted to prevention. However, as already stated, this question was not particularly relevant because the majority of respondent's offices were devoted to prevention. Thus, this question was also discarded.

One question from the Phase II survey was discarded. The respondents were asked to indicate which *one* of a number of services best described their program. This item was discarded because 53 percent of respondents selected more than one category.

2.4.3   *Data Coding*

Open-ended responses from the Phase I interviews and Phase II surveys were coded into quantifiable categories.

2.4.3.1   *Phase I*

The Phase I surveys included three open-ended questions: (1) perceived need in the Commonwealth, (2) agency's main goals and objectives, and (3) types of training/TA provided to the field. Responses to the questions regarding prevention needs in the Commonwealth were coded into 11 categories:

- *Collaboration among agencies;*
- *Prevention of ATOD use;*
- *Violence prevention;*
- *Additional resources for prevention services;*
- *Services for very young children;*
- *A comprehensive, systems-based approach involving science based services;*
- *Improving skills (life, critical thinking, social);*
- *Family planning;*
- *Parenting skills;*
- *Affordable, safe housing;* and
- *Professional development and education.*

Responses to the question regarding program goals and objectives were coded into 11 categories:

- *Program evaluation/monitoring, development;*
- *Public safety;*
- *Prevention of violence;*
- *Prevention of ATOD use;*
- *Prevention of sexual activity, pregnancies, STDs;*
- *Providing opportunities for positive alternative activities;*
- *Family management/parenting skills;*
- *Life skills/social skills training;*
- *Meeting needs of localities;*
- *Injury prevention;* and
- *Improving health outcomes.*

Responses to the question regarding training provided to the field were coded into the following categories, based on the responses:

- *Prevention planning;*
- *Program management/development/collaboration;*
- *Training specific to program objectives;*

- *Current prevention research;*

- *Ongoing TA;*

- *Staff skills;*

- *Program evaluation;*

- *Funding opportunities/grant writing;* and

- *Training specific to need of locality.*

2.4.3.2   *Phase II*

The Phase II surveys included two open-ended questions: perceived prevention needs in the locality and the program's main goal and objectives. Responses for the perceived prevention needs question were coded into the following categories, based on the responses:

- *ATOD use;*

- *Child abuse prevention;*

- *Teen pregnancy prevention;*

- *Family violence prevention;*

- *School commitment;*

- *Not enough opportunities for positive activities;*

- *Negative ATOD attitudes/norms against ATOD use;*

- *Poor family management skills;*

- *Little involvement of others in prevention activities (parents, schools, community);*

- *Not enough early intervention resources/programs;*

- *Delinquency;*

- *Violence;*

- *Little affordable housing;*

- *Access to healthcare;* and

- *Prevention of STDs.*

Responses for the questions regarding main goals and objectives of the agency were coded into 19 categories:

- *Providing opportunities for positive activities;*

- *Increasing family management/parenting skills;*

- *Life skills/social skills training;*

- *Prevention of ATOD use;*

- *Delinquency prevention;*

- *Mentoring;*
- *Health promotion/access;*
- *Increasing school commitment/success;*
- *Community-based planning;*
- *Acting as advocates/policy change;*
- *Improving prenatal health care;*
- *Family self-sufficiency;*
- *Mental health services;*
- *Providing youth support/increase self-esteem;*
- *Family empowerment;*
- *Changing attitudes/norms against ATOD use;*
- *Collaboration with other agencies;*
- *Crisis intervention;* and
- *Decreasing violence.*

2.4.3.3   *Statistical Analysis*

Descriptive statistical analyses were conducted examining the following variables:

- Prevention needs;
- Staff capabilities;
- Program objectives;
- Budget and funding;
- Program strategies;
- Program participant demographics;
- Program objective;
- Evaluation and collaboration activities; and
- Barriers to service.

As discussed earlier, data analysis was conducted separately for each data collection phase. Ranges and averages of ratings obtained from the respondents were used to describe responses at the Commonwealth and HPR levels. The results are presented in the following chapter.

3. FINDINGS

This chapter presents the detailed findings from analysis of the Phase I and Phase II data collected for the Community Resource Assessment.

3.1   Phase I Findings

The following section presents the findings from Phase I of the Community Resource Assessment. Phase I findings are only presented at the State level, which was the basis for information provided by Phase I respondents.

3.1.1   *Prevention Needs*

Respondents were asked to indicate what they believed were the greatest prevention needs in the Commonwealth of Virginia in order to assess perceived prevention needs at the State level.

Exhibit 3-1 presents the findings for Phase I respondents' perceived prevention needs in the Commonwealth. The most common response reported by Phase I respondents was the need for a more comprehensive science-based systems approach to prevention (26.3%), followed by the need for additional prevention resources (23.7%) and the need for collaboration among agencies/organizations providing prevention services at both the State and local levels (21.1%).

Exhibit 3-1. Commonwealth Perceptions of Prevention Needs: Phase I Respondents
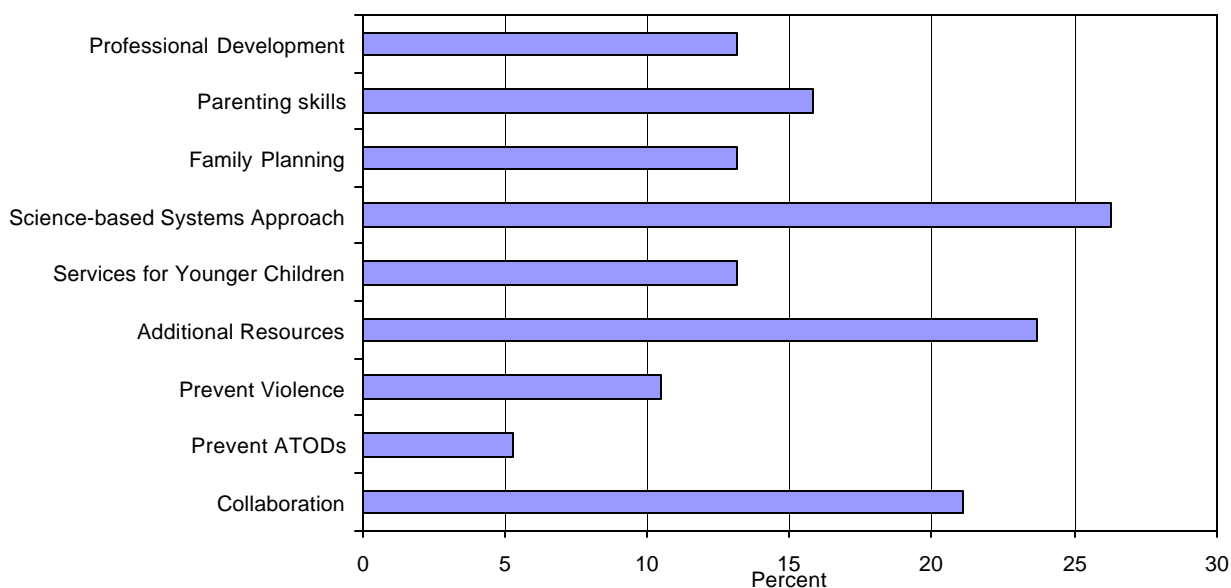
3.1.1.1   *Goals and Objectives*

Phase I respondents were asked, in an open-ended question, to report their offices' main goals or objectives.

Exhibit 3-2 presents the findings for the agencies reported main goals and objectives. In the Commonwealth, the most common objective was *building effective prevention programs in the field through program monitoring, training, and program evaluation* (34.2%), followed by *meeting the needs of localities, including local citizens and local programs* (18.4%), and the *prevention of ATOD use* (16%).

Exhibit 3-2. Program Objectives: Phase I Respondents
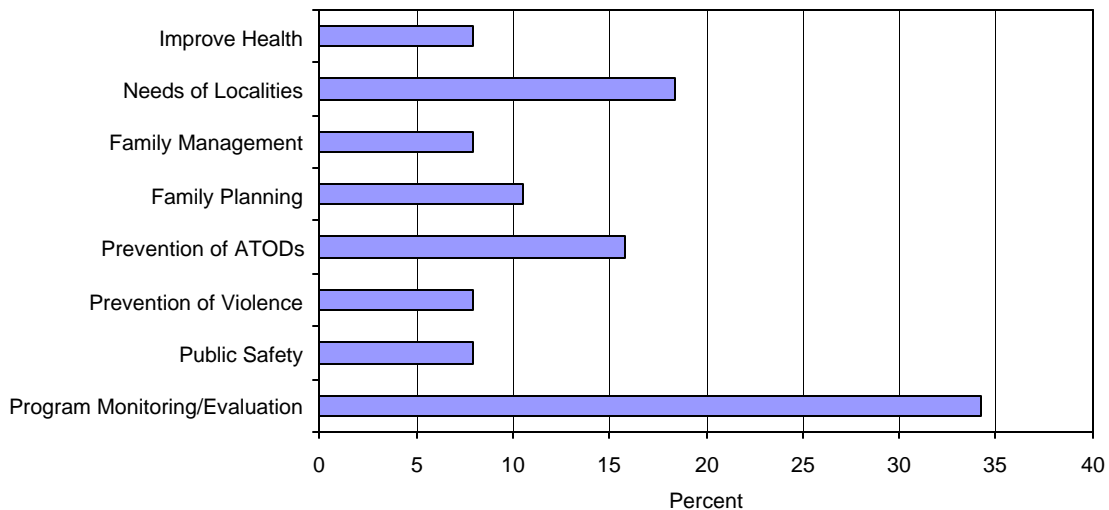
3.1.2   *Services Provided*

To collect information on the types of services provided by State-level agencies/organizations, respondents were asked to indicate which types of services their office provided. The findings include services provided by local programs under the auspices of the State-level agency/organization (i.e., local health departments). The findings are categorized into services provided within the individual, family, school, and community domains.

3.1.2.1 *Individual Domain*

Exhibit 3-3 presents the findings on services provided in the individual domain. The most common service reported by Phase I respondents was Life Skills/Social Skills Training (71.1%). Drug-Free Activities and Mentoring Services were the second most common services reported by Phase I respondents (63.2%). The third most common response was Peer Leadership Programs (57.9%).

Exhibit 3-3. Services Provided at the State and Local Level—Individual Domain: Phase I Respondents
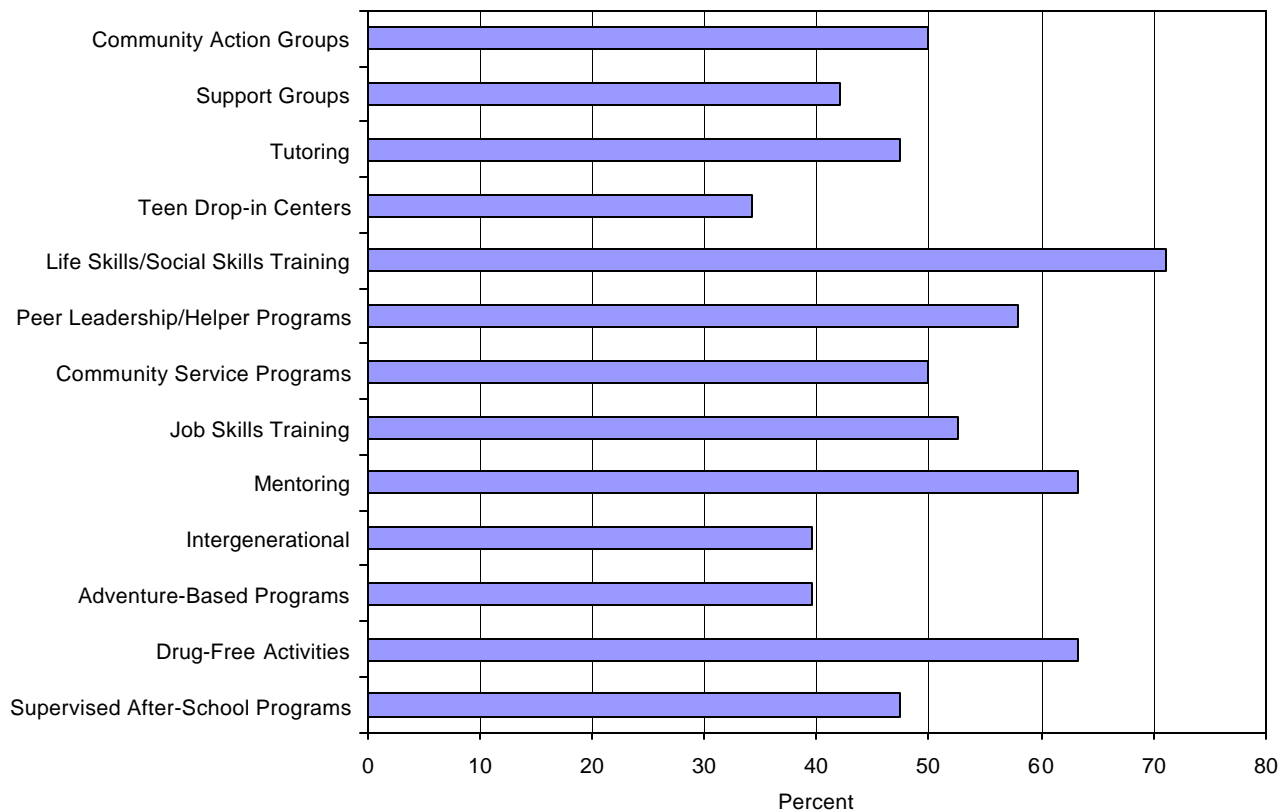
3.1.2.2   *Family Domain*

Exhibit 3-4 presents the findings on reported services provided in the family domain. The most common service reported by Phase I respondents was Parenting/Family Management Training (63.2%). Approximately 53 percent of respondents reported that Prenatal/Infancy Services were provided by their organization, the second most c ommon response. Half of all respondents reported that Family Support Services were provided by their organization, the third most common response.

Exhibit 3-4. Services Provided at the State and Local Level—Family Domain: Phase I Respondents
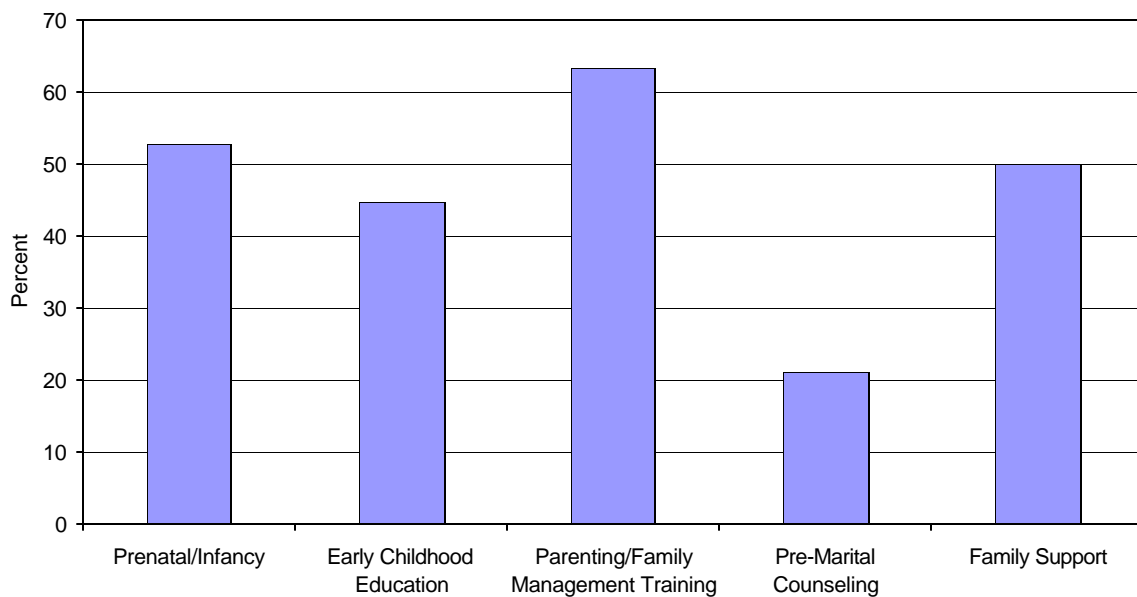
3.1.2.3   *School Domain*

Exhibit 3-5 presents the findings on reported services in the school domain. The responses obtained from Phase I respondents revealed that the provision of services related to Organizational Change In School was the most commonly reported service (50%). The second most common services reported by Phase I respondents included services related to Behavior Management and the development of School Policies That Discourage Substance Use (42.1%).

Exhibit 3-5. Services Provided at the State and Local Level—School Domain: Phase I Respondents
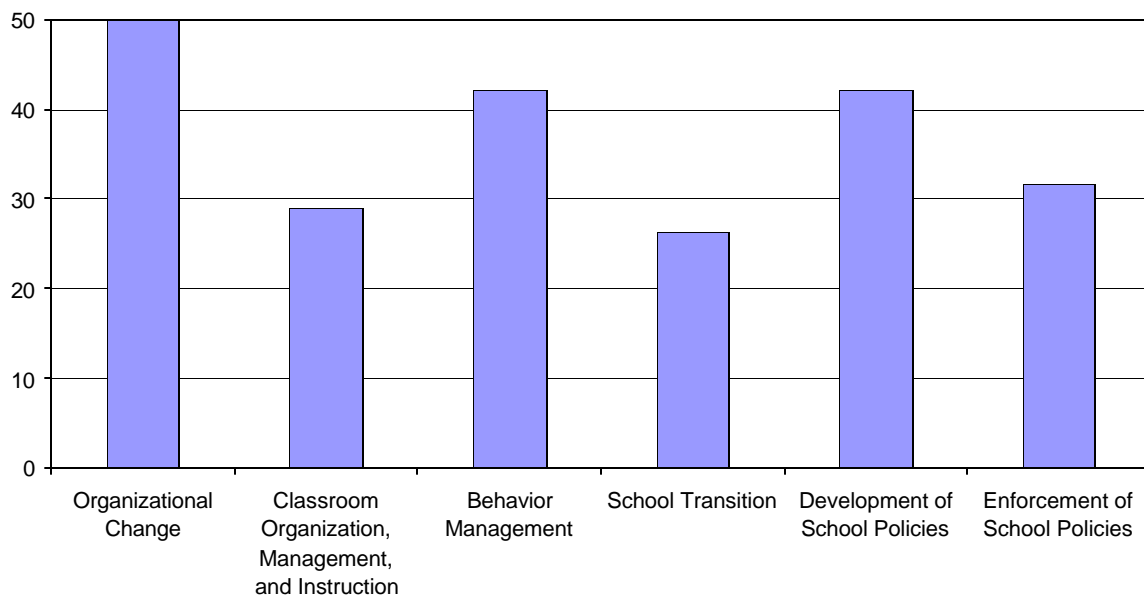
3.1.2.4   *Community Domain*

Exhibit 3-6 presents the findings on the provision of services in the community domain. The most common service reported by Phase I respondents was Information Dissemination (94.7%), followed by the provision of services related to Community Development and Capacity Building (81.6%), and engagement in Media Campaigns (78%).

Exhibit 3-6. Services Provided at the State and Local Level—Community Domain: Phase I Respondents
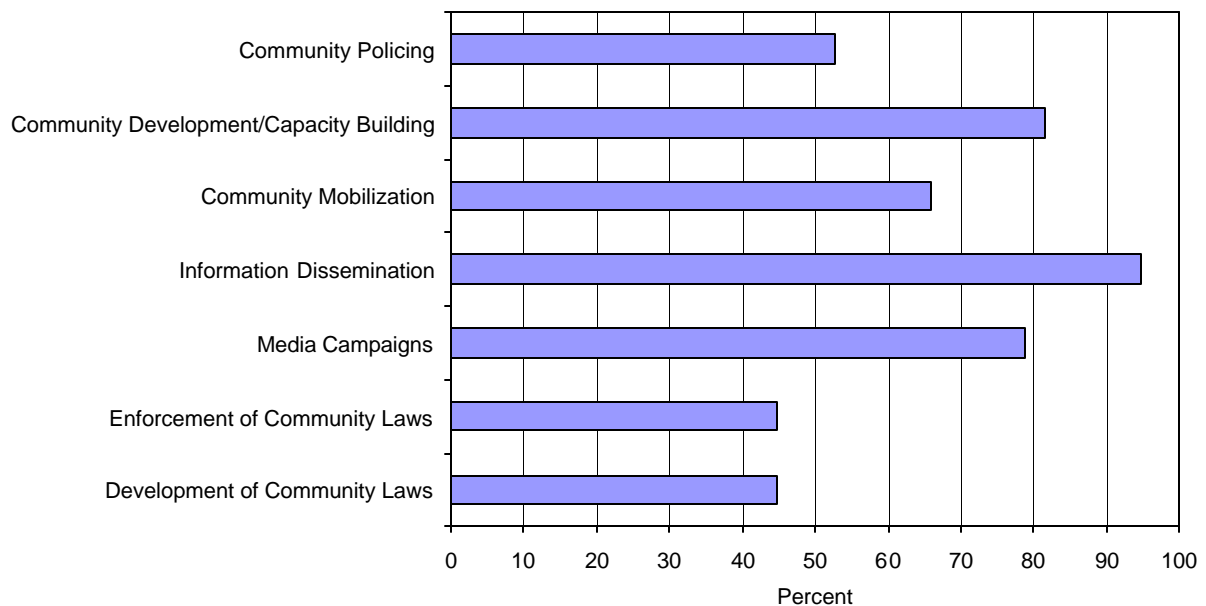
3.1.3   *Prevention Funding*

To obtain information on prevention funding at the State level, respondents were asked to report the annual budget for their office, funding sources, and changes in funding within the past year.

3.1.3.1   *Budget*

The average annual budget for prevention programs at the State level in the Commonwealth was $10,010,128. Annual budgets reported by Phase I respondents ranged from $10,000 to $64,000,000.

3.1.3.2 *Funding Source*

Exhibit 3-7 presents the findings on the funding sources reported by Phase I respondents. This information includes sources of funding for local offices under the auspices of the State-level organizations. The most commonly reported sources of funding were Federal grants or contracts (81.6%) and State agencies (81.6%). The second most common source of funding was local funds (65.8%). Relatively few participants reported receiving funds from program fees (26.3%).

Exhibit 3-7. Sources of Funding: Phase I Respondents
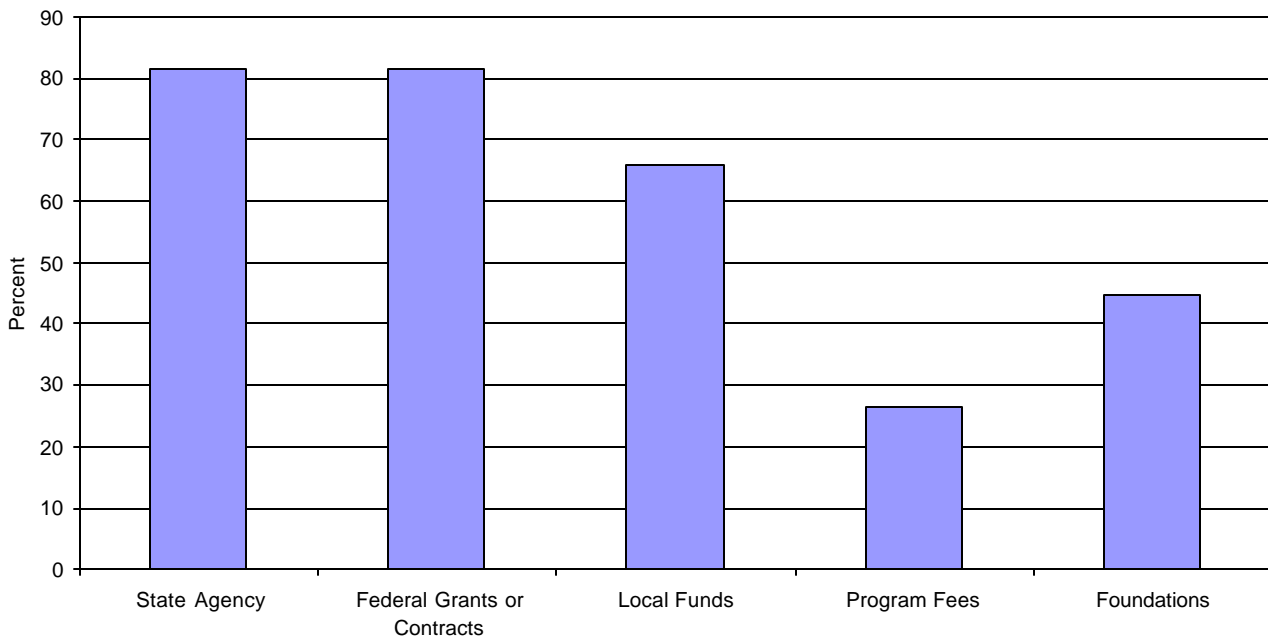
3.1.3.3 *Change in Funding*

Exhibit 3-8 presents the findings on reported changes in funding within the past year. Over half of the respondents reported that there were no changes in funding to their offices within the past year. Approximately 15 percent of respondents reported that funding had either doubled, increased somewhat, or decreased somewhat. No respondents reported that their funding had been cut in half or more.

Exhibit 3-8. Changes in Funding

Doubled or more than doubled	Increased somewhat	Stayed about the same	Decreased somewhat	Was cut in half or more than half
14.7%	14.7%	55.9%	14.7%	0%

3.1.4   *Staff*

To obtain information on prevention staff, respondents were asked to indicate the number of full-time and volunteer workers employed in their office; credentials of office directors, and types of staff training.

3.1.4.1   *Number of Employees*

On average in the Commonwealth, Phase I respondents reported that 16.31 full-time staff were employed in their office. However, due to the diverse types and sizes of organizations interviewed, the range of responses varied widely. The reported number of full-time staff ranged from 1 to 260. On average, the number of volunteers reported by Phase I respondents was 692. However, again the range of values for this question was quite diverse. The reported number of volunteer staff ranged from 0 to 24,000.

3.1.4.2   *Credentials/Training*

To collect information on staff experience, respondents were asked for their years of work experience in the prevention field, years of work experience at the particular office for which they were currently managing, and types of staff training. On average, Phase I respondents reported that they had worked in the prevention field for 16 years, ranging from 2 to 35 years. In addition, Phase I respondents, on average, had worked in their current position for 5.32 years, ranging from .5 to 18 years. Exhibit 3-9 presents the findings on the types of training staff received in the past year. Three types of training were reported by the majority of Phase I respondents. More than 70 percent of respondents (72.1%) reported that they and their staff had received training in coalition building, program monitoring, and cultural awareness.

Exhibit 3-9. Type of Staff Training: Phase I Respondents
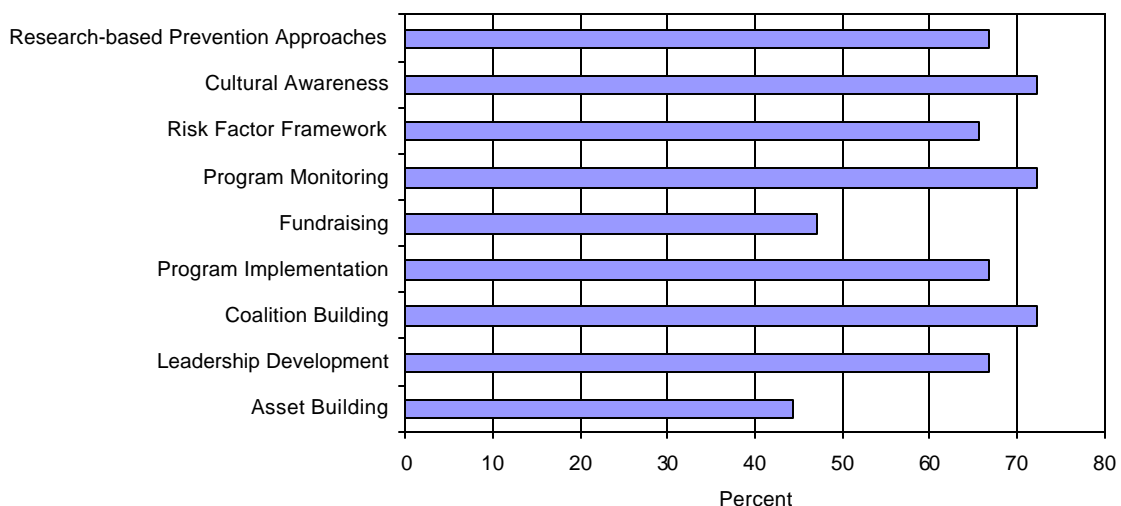
3.1.5 *Data Collection and Evaluation*

To gather information on data collection and evaluation, respondents were asked to report types of data they collected, types of data they used for planning, and types of data they provided to others, and when program evaluation data were collected.

3.1.5.1 *Data Collection*

Respondents were asked to indicate which types of data their office collected. Exhibit 3-10 presents the findings for the Commonwealth. The overwhelming majority of Phase I respondents reported that they collected data on program descriptions (91.9%), followed by populations served (89.2%), program evaluation (86.1%), and program monitoring (83.8%). More than 50 percent of Phase I respondents reported collecting data for the following purposes:

- Prevention needs (59.5%);
- Drug use and crime rates (59.5%); and
- Clearinghouse/resource centers (59.5%).

Exhibit 3-10. Type of Data Collected: Phase I Respondents
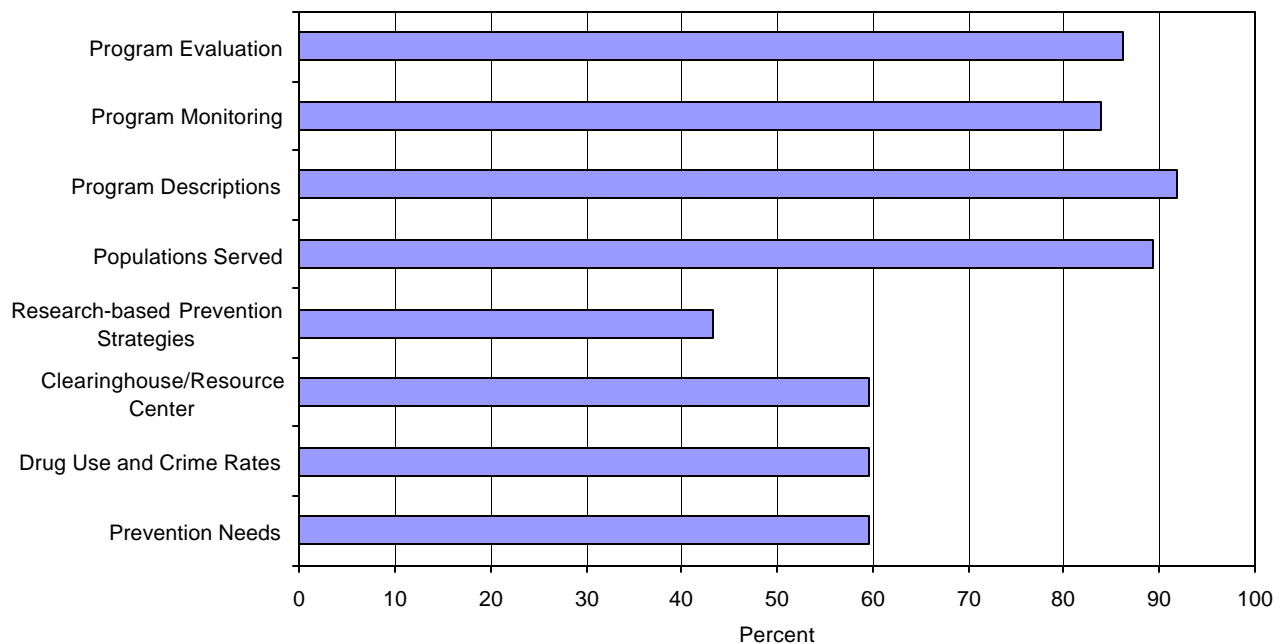
3.1.5.2   *Data Planning*

Exhibit 3-11 presents the findings for the types of data used for planning in the Commonwealth. The most commonly reported use of data for planning was program evaluation data (69.4%). The second most common response was drug use and crime rates (67.6%), and the third was the use of prevention needs data for prevention planning (56.8%).

Exhibit 3-11. Type of Data Used for Planning: Phase I Respondents
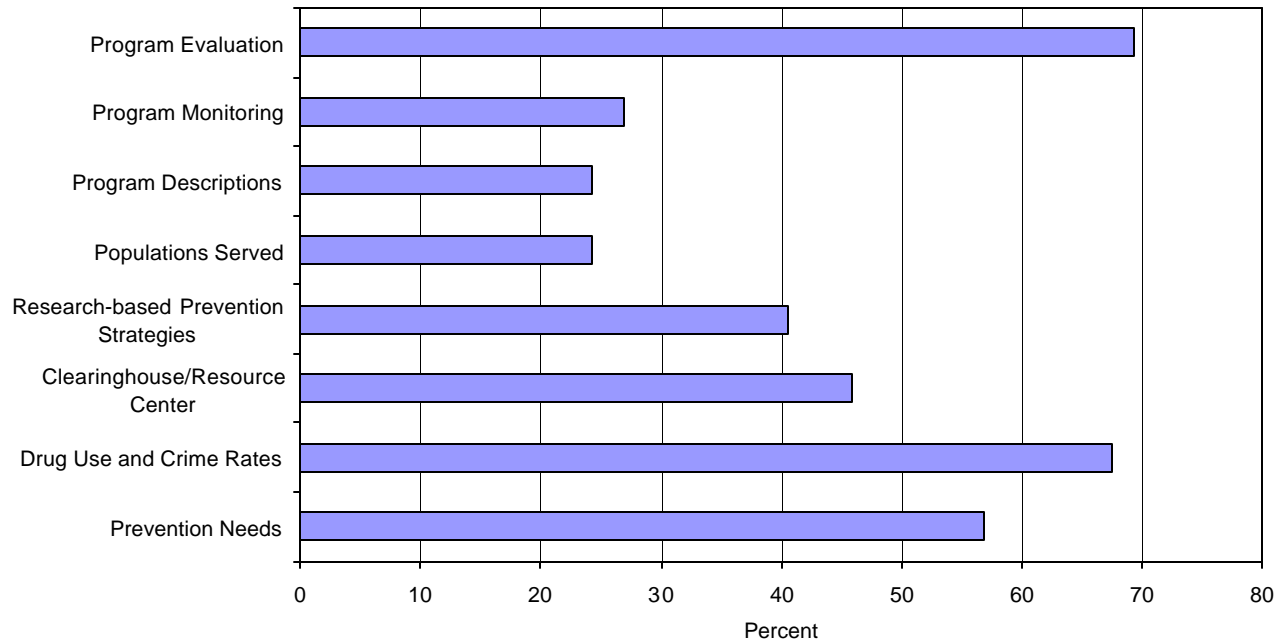
3.1.5.3   *Data Provision*

Exhibit 3-12 presents the findings on the types of data Phase I respondents provide to others. The most common response was program evaluation data (83.3%). The second most common response was program descriptions (81.1%). Seventy-eight percent of respondents reported that they provide data on populations served to others, the third most common response.

Exhibit 3-12. Types of Data Provided to Others: Phase I Respondents
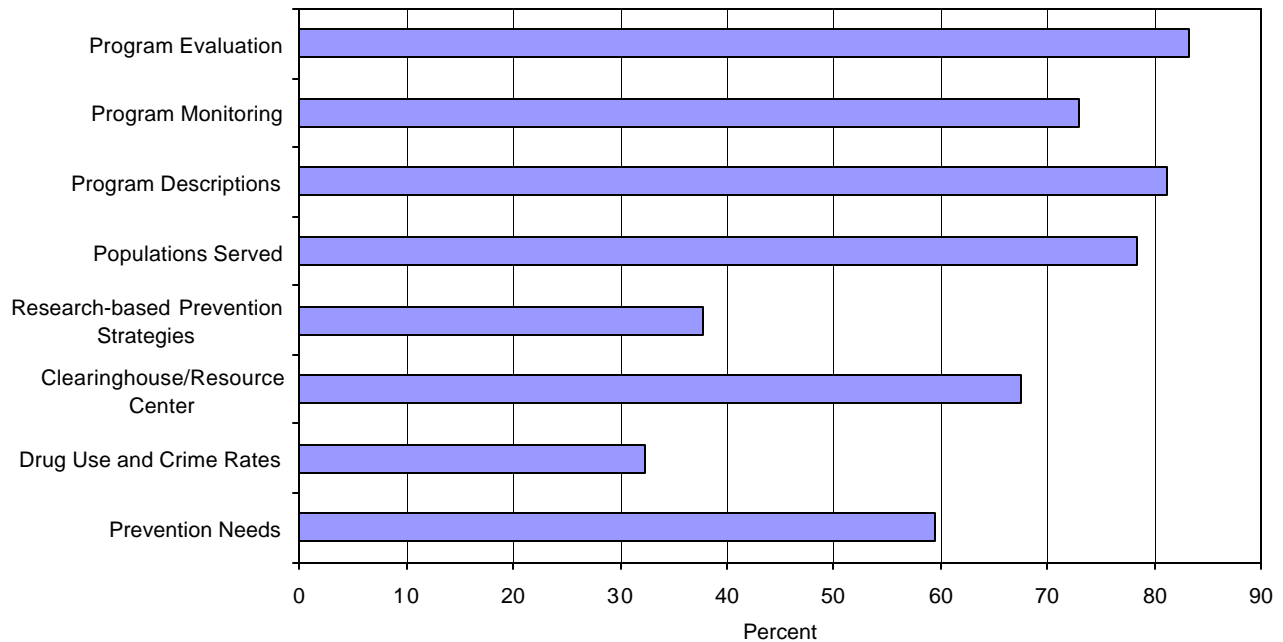
3.1.5.4   *Evaluation Data*

As stated in the previous section, the majority of Phase I respondents reported that they collected program evaluation data.

Exhibit 3-13 presents the findings of when the respondents reported collecting p rogram evaluation data. The most common time of data collection reported by Phase I respondents was before the program began and immediately after the program ended to compare differences (66.7%). The second most common response was multiple times during the program (41.7%). The third most common times of data collection were only immediately following the end of the program and long-term followup (37.5%).

Exhibit 3-13. Times of Data Collection—Outcome Evaluation: Phase I Respondents
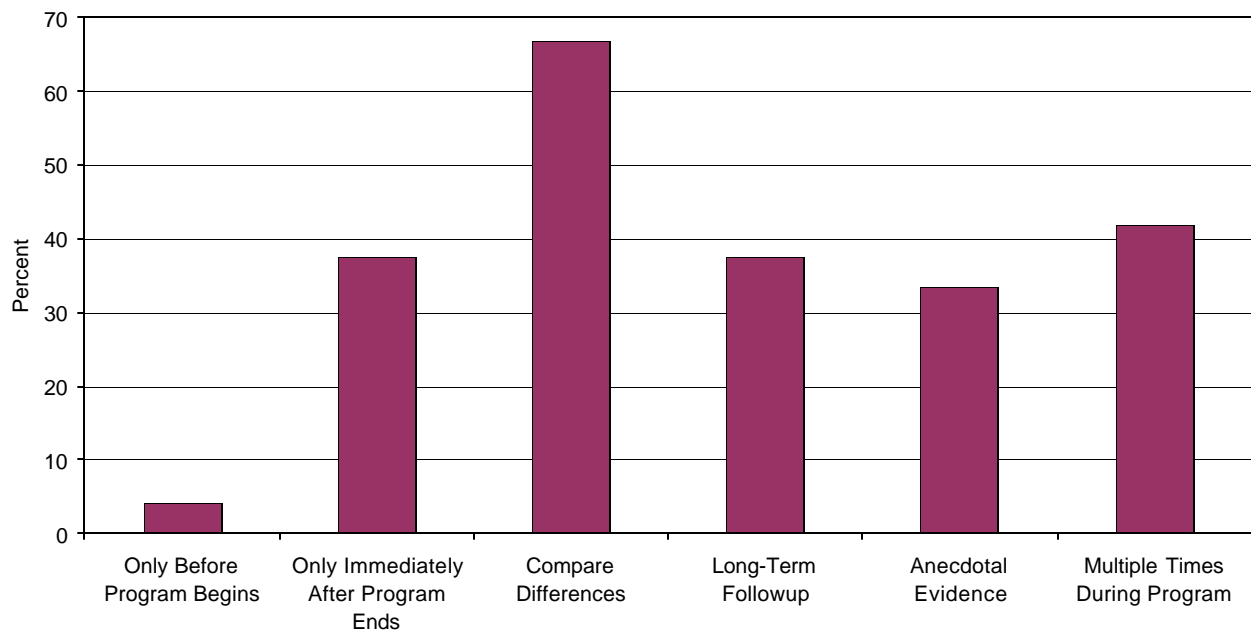
3.1.6   *Program Collaboration*

To obtain information on collaboration, Phase I respondents were asked if and with whom they collaborated with in joint prevention planning.

Over 95 percent of respondents reported that they collaborated with other agencies/organizations on joint planning. Exhibit 3-14 presents the findings on the types of agencies with which joint planning was conducted. The most common response of Phase I respondents was that they collaborated with schools on joint planning (80%). The second most common agency to engage in joint planning was local health departments (76.5%), followed by local social service agencies (71.4%).

Exhibit 3-14. Agencies with Whom Respondents Participate in Joint Prevention Planning: Phase I Respondents
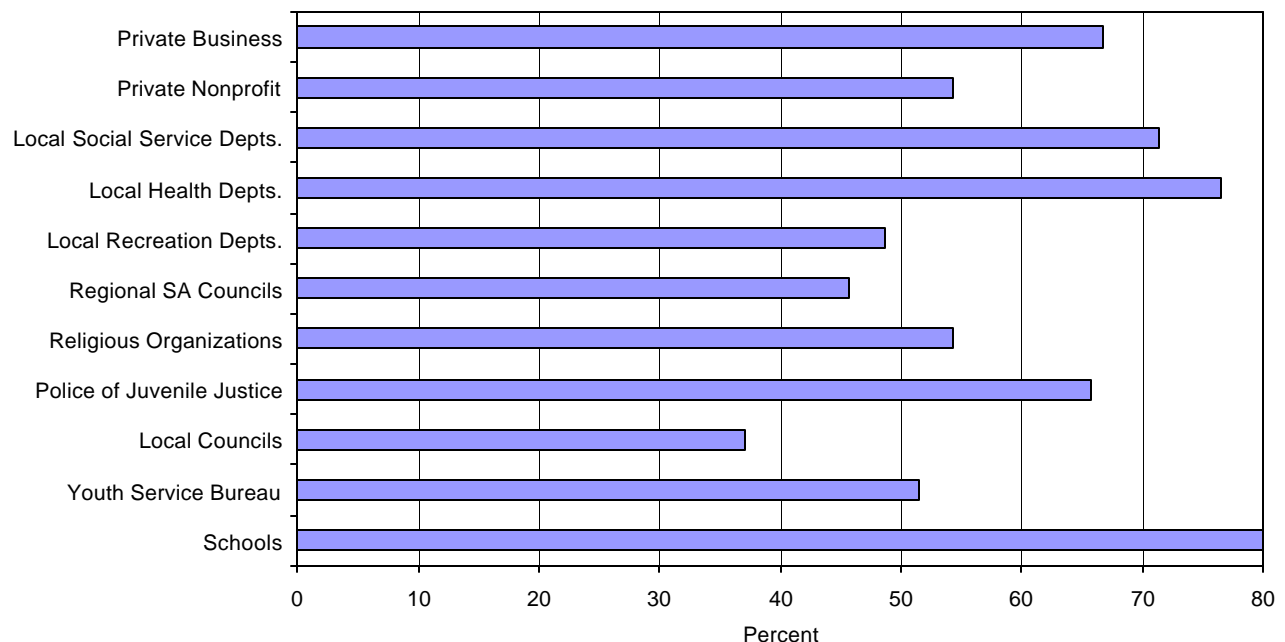
3.1.7   *Program Barriers*

Exhibit 3-15 presents the findings on the reported barriers to service provision in the Commonwealth. Fifty percent of Phase I respondents reported that insufficient staff due to a lack of funding was a significant barrier. Lack of transportation to and from services was the second most commonly reported significant barrier (32.2%), followed by staff turnover (25%). More than half of Phase I respondents reported that insufficient collaboration with community agencies was a minor to moderate barrier (56.2%), followed by lack of public awareness (53.2%) and cultural differences (50%).
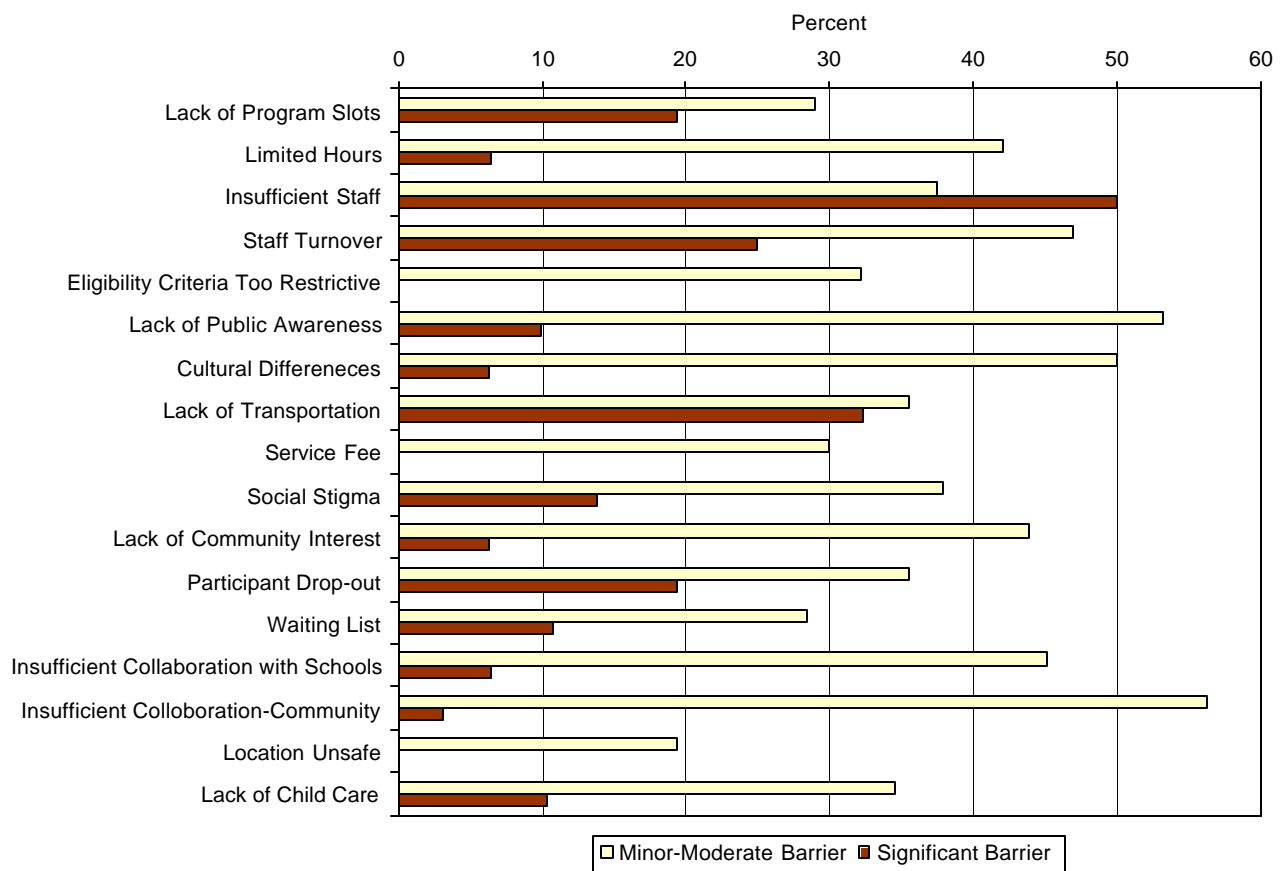
Exhibit 3-15. Barriers to Service Delivery: Phase I Respondents

3.1.8   *Training Provided to the Field*

To obtain information on the types of training that State-level agencies/ organizations provided to the field, Phase I respondents were asked, in an open-ended question, to report the types of training they provided to the field.

Exhibit 3-16 presents the findings on the types of training provided to the field. The most common training reported by Phase I respondents (63.2%) was training that was specific to each particular program (i.e., daycare providers may receive training on State code for daycare centers, information on how to care for children, etc.). The second most common training provided to the field was on program management and development (34.2%), followed by grant writing and funding opportunities (29%).

Exhibit 3-16. Types of Training Provided to the Field: Phase I Respondents
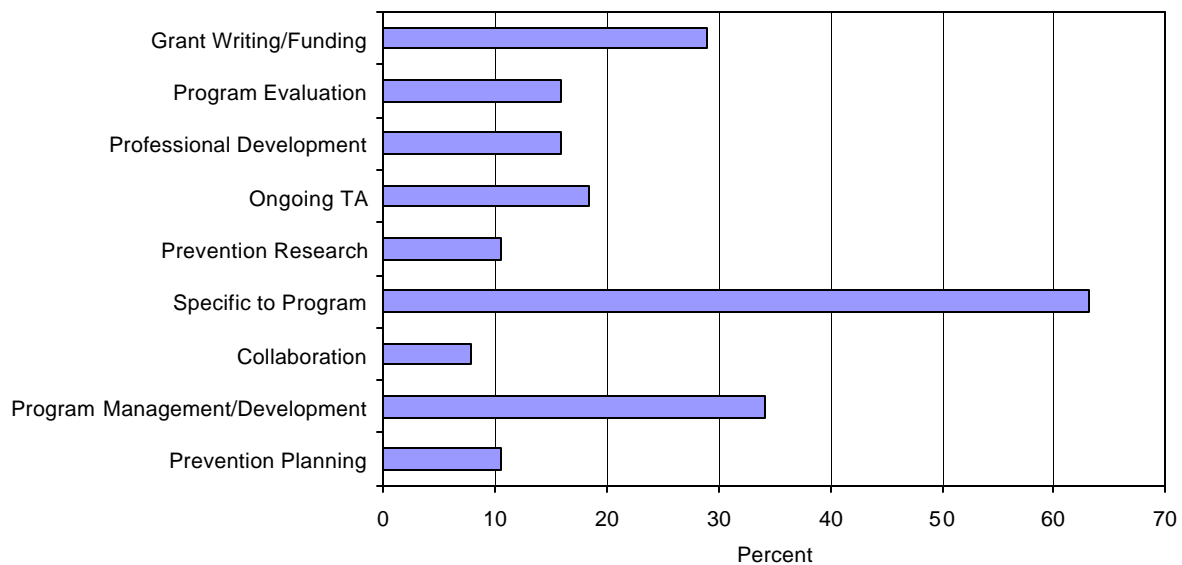
3.2   PHASE II Findings

The following section presents the findings from Phase II of the Community Resource Assessment. The findings are presented at the State level and for each of the five Health Planning Regions (HPRs) in the Commonwealth of Virginia. The geographical regions covered within the five HPRs in Virginia are presented below.

Health Planning Regions of Virginia

Health Planning Region I
Health Planning Region II
Health Planning Region III
Health Planning Region IV
Health Planning Region V
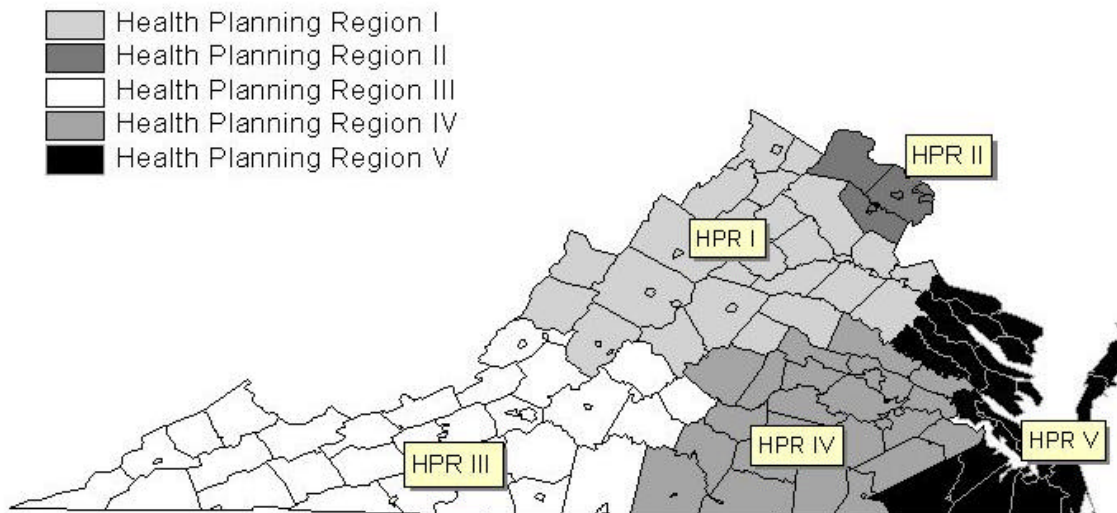
3.2.1   *Perceived Prevention Needs*

To assess perceived prevention needs within communities, respondents were asked to indicate what they believed were the greatest prevention needs in their localities.

Exhibit 3-17 presents the findings for reported prevention needs in the Commonwealth. The most common need reported by respondents was *substance use prevention* (49.5%), followed by *teen pregnancy prevention* (24.4%), and *family management/parenting skills* (19.2%).

Due to the wide range of prevention programs surveyed, respondents reported a variety of prevention needs. Therefore, for the majority of prevention need categories, less than 10 percent of respondents indicated that these needs were a problem. These include:

- *Decrease school drop-out/increase school commitment* (10%);

- *Domestic violence prevention* (7.8%);

- *Increase involvement of community, faith-based organizations, parents and/or schools in prevention activities* (7.8%);

- *Child abuse prevention* (7.2%);

- *Resources related to providing prevention services* (i.e., funding, space, etc.) (7.2%);

- *Early intervention* (4.9%);

- *Attitudes/norms regarding ATOD use* (3.3%); and

- *Delinquency prevention* (3.3%).

Exhibit 3-17. Commonwealth Reported Prevention Needs: Phase II Respondents
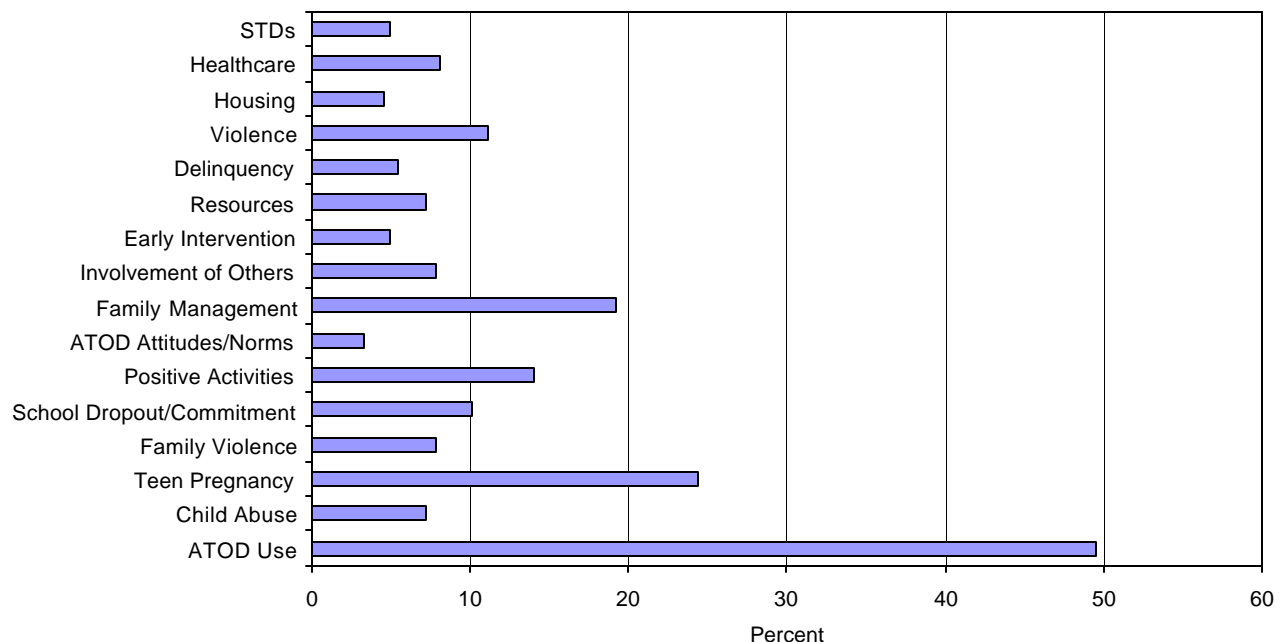
Exhibit 3-18 presents the findings for reported prevention needs in HPR I. Similar to the Commonwealth, the three most commonly reported needs in HPR I were *substance use prevention* (51.7%), *teen pregnancy prevention* (25.9%), and *family management* (22.4%). Less than 10 percent of respondents reported the following needs:

- *Increase availability of affordable housing* (6.9%);

- *Increase availability of positive activities* (6.9%);

- *Increase access to healthcare* (6.9%);

- *Early intervention* (6.9%);

- *Child abuse prevention* (5.2%);

- *Domestic violence prevention* (5.2%);

- *Increase involvement of community, faith-based organizations, parents and/or schools in prevention activities* (3.4%);

- *Delinquency prevention* (3.4%);

- *Violence prevention* (3.4%);

- *STD prevention* (0%); and

- *Attitudes and norms regarding ATOD use* (0%).

Exhibit 3-18. HPR I Reported Prevention Needs: Phase II Respondents
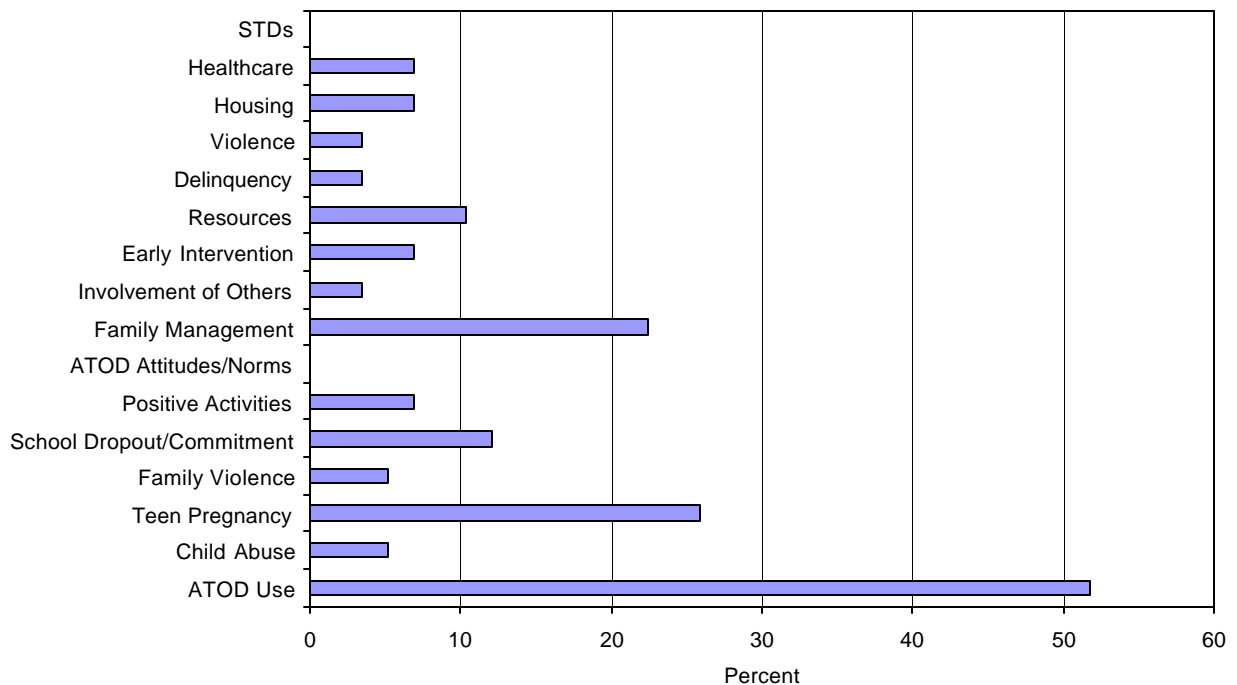
Exhibit 3-19 presents the findings for reported prevention needs in HPR II. In HPR II, the three most commonly reported needs included *substance use prevention* (36.6%), *increasing the availability of positive activities* (15.5%), and *family management* (15.5%). All other needs (excluding violence, 11.3%) were reported by fewer than 10 percent of respondents.

Exhibit 3-19. HPR II Reported Prevention Needs: Phase II Respondents
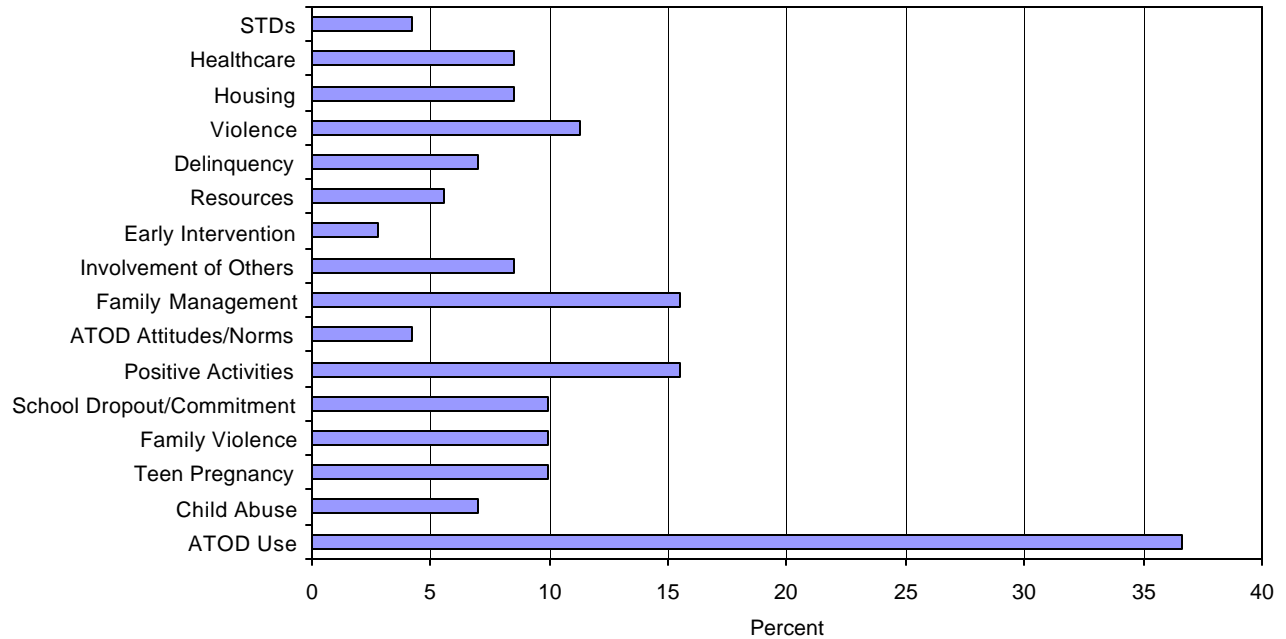
Exhibit 3-20 presents the findings for reported prevention needs in HPR III. In HPR III, the three most commonly reported needs were *substance use prevention* (48.6%), *teen pregnancy prevention* (21.4%), and *increasing the availability of positive activities* (17.1%). Less than 10 percent of respondents reported the following needs:

- *Increase access to healthcare* (8.6%);

- *Early intervention* (7.1%);

- *Attitudes/norms regarding ATOD use* (4.3%);

- *Delinquency prevention* (4.3%);

- *Child abuse prevention* (2.9%);

- *STD prevention* (2.9%);

- *Domestic violence prevention* (1.4%); and

- *Increase availability of affordable housing* (1.4%).

Exhibit 3-20. HPR III Reported Prevention Needs: Phase II Respondents
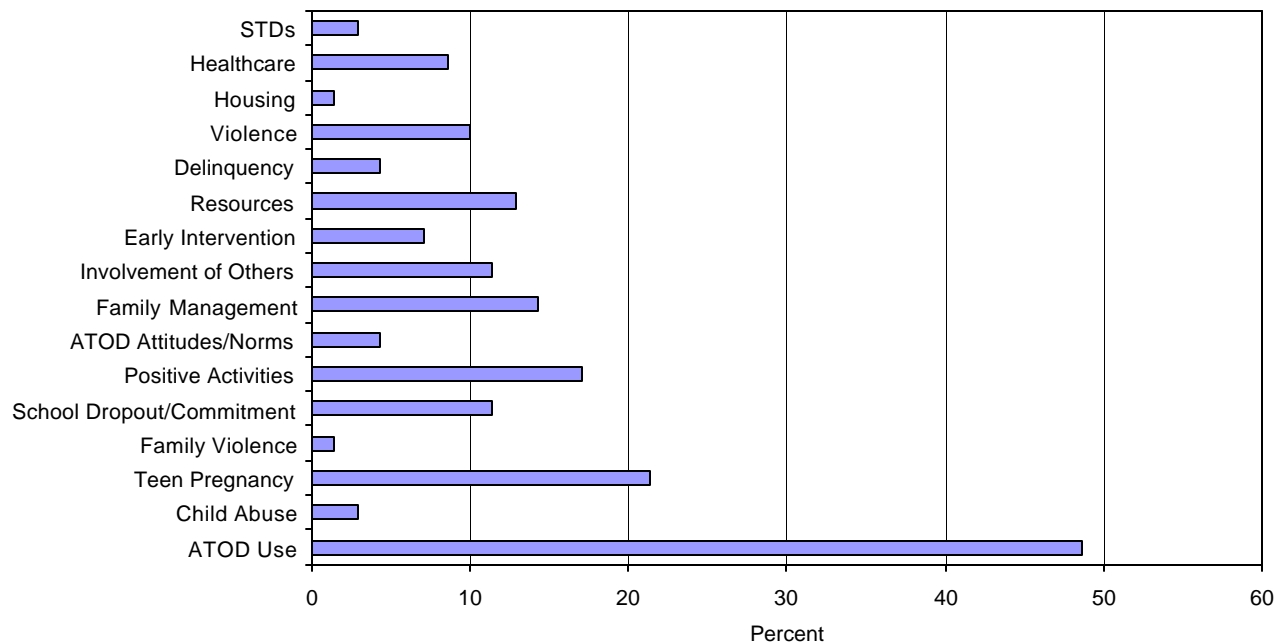
Exhibit 3-21 presents the findings for reported prevention needs in HPR IV. The majority of respondents reported that *substance abuse prevention* was a need in their communities (63.3%). Forty-two percent of respondents indicated that *teen pregnancy prevention* was a prevention need. The third most common need was *violence prevention*, reported by 21 percent of respondents.

Less than 10 percent of respondents reported the following needs:

- *Increase access to health care* (8.3%)
- *Child abuse prevention* (8.3%);
- *Delinquency prevention* (8.3%);
- *Increase resources* (8.3%);
- *STD prevention* (8.3%);
- *Attitudes/norms regarding ATOD use* (3.3%);
- *Early intervention* (3.3%); and
- *Increase availability of affordable housing* (3.3%).

Exhibit 3-21. HPR IV Reported Prevention Needs: Phase II Respondents
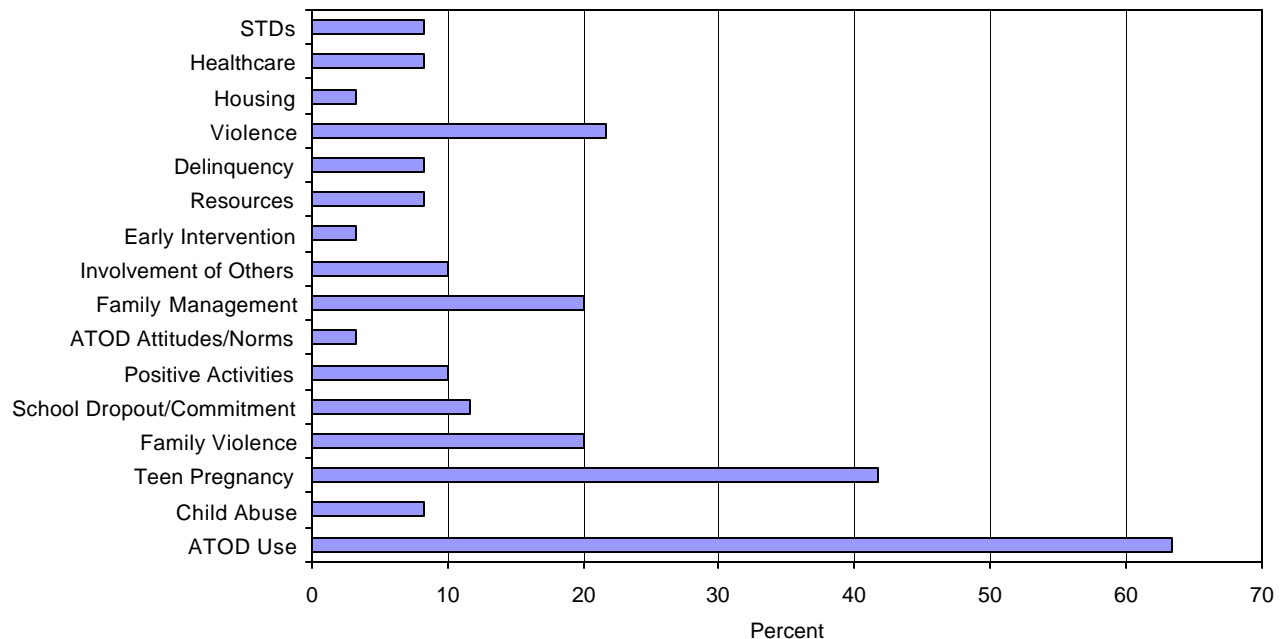
Exhibit 3-22 presents the findings for reported prevention needs in HPR V. The most common prevention need reported by respondents in HPR V was *substance use prevention* (51.7%). The second and third most commonly reported needs were *teen pregnancy prevention* (23.3%) and *family management skills* (23.3%), respectively.

Less than 10 percent of respondents indicated that the following were prevention needs in their communities:

- *Increase access to healthcare* (8.3%);
- *Violence prevention* (8.3%);
- *STD prevention* (8.3%);
- *Early intervention* (6.7%);
- *Decrease school drop-out/increase school commitment* (5.0%);
- *Attitudes/norms regarding ATOD use* (3.3%);
- *Increase involvement of community, faith-based organizations, parents and/or schools in prevention activities* (3.3%);
- *Delinquency prevention* (3.3%);
- *Family violence* (1.7%);
- *Increase available affordable housing* (1.7%); and
- *Increase resources* (0%).

Exhibit 3-22. HPR V Reported Prevention Needs: Phase II Respondents
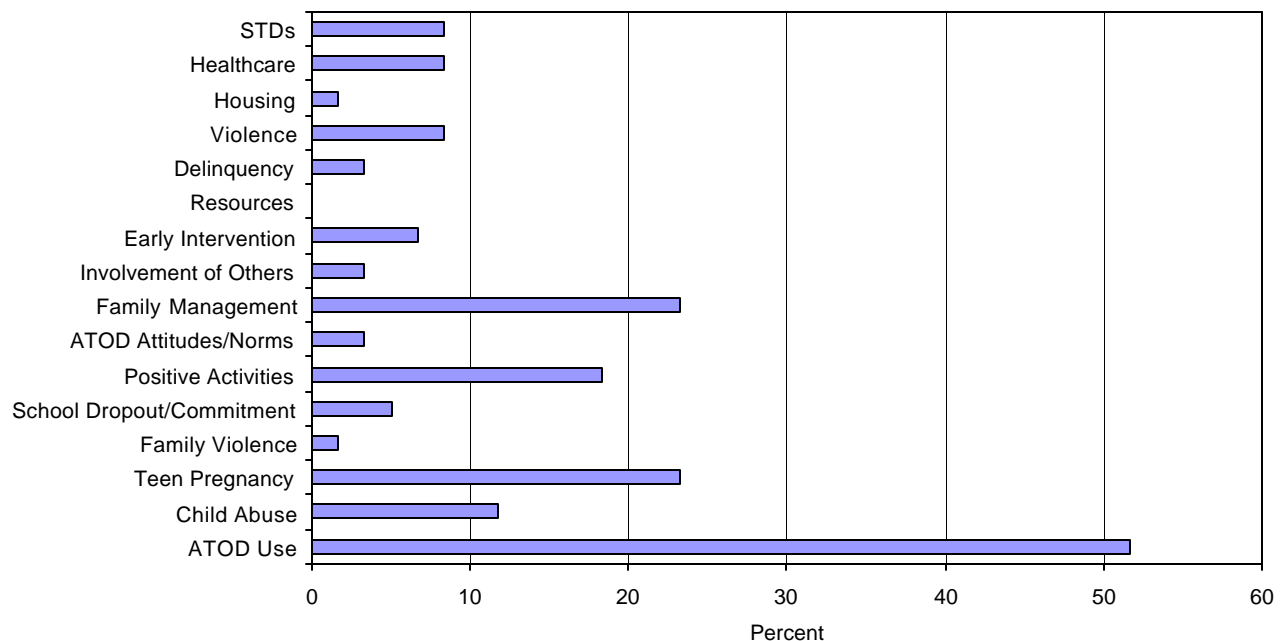
In summary, the most common need reported by respondents in all five HPRs was *substance abuse prevention. Teen pregnancy prevention* was another commonly reported need in HPRs I, III, IV, and V. HPR II was the only HPR in which *teen pregnancy prevention* was not one of the three most commonly reported needs. Respondents in HPRs I, II, and V reported that *family management skills* are a need. In HPRs II and III, *lack of available positive activities* was also a common need. Only respondents in HPR IV reported that *violence prevention* was a common need.

3.2.2   *Goals and Objectives*

Respondents were asked two questions to collect information on program goals and objectives. In an open-ended question, respondents were asked to indicate the main focus of their program. In a close-ended question, respondents were asked to select from a list of goals and objectives which ones were a main program focus.

3.2.2.1   *Program Focus*

Responses from the open-ended question were coded into 22 categories. The following section describes the findings from the open-ended question regarding the main program focus.

Exhibit 3-23 presents the findings for the Commonwealth. In the Commonwealth, the most common program focus was Life Skills/Social Skills Training (18.9%). The second most commonly reported program focus was Family Management Skills: 17 percent of respondents in the Commonwealth reported that providing Family Management Skills, including anger management and family management training, was a main program focus. More than 15 fifteen percent of respondents reported that providing Positive Alternative Activities for Youth was a main program focus.

Less than 10 percent of respondents reported that the other categories were a main focus of their program.

Exhibit 3-23. Program's Main Focus—Commonwealth: Phase II Respondents
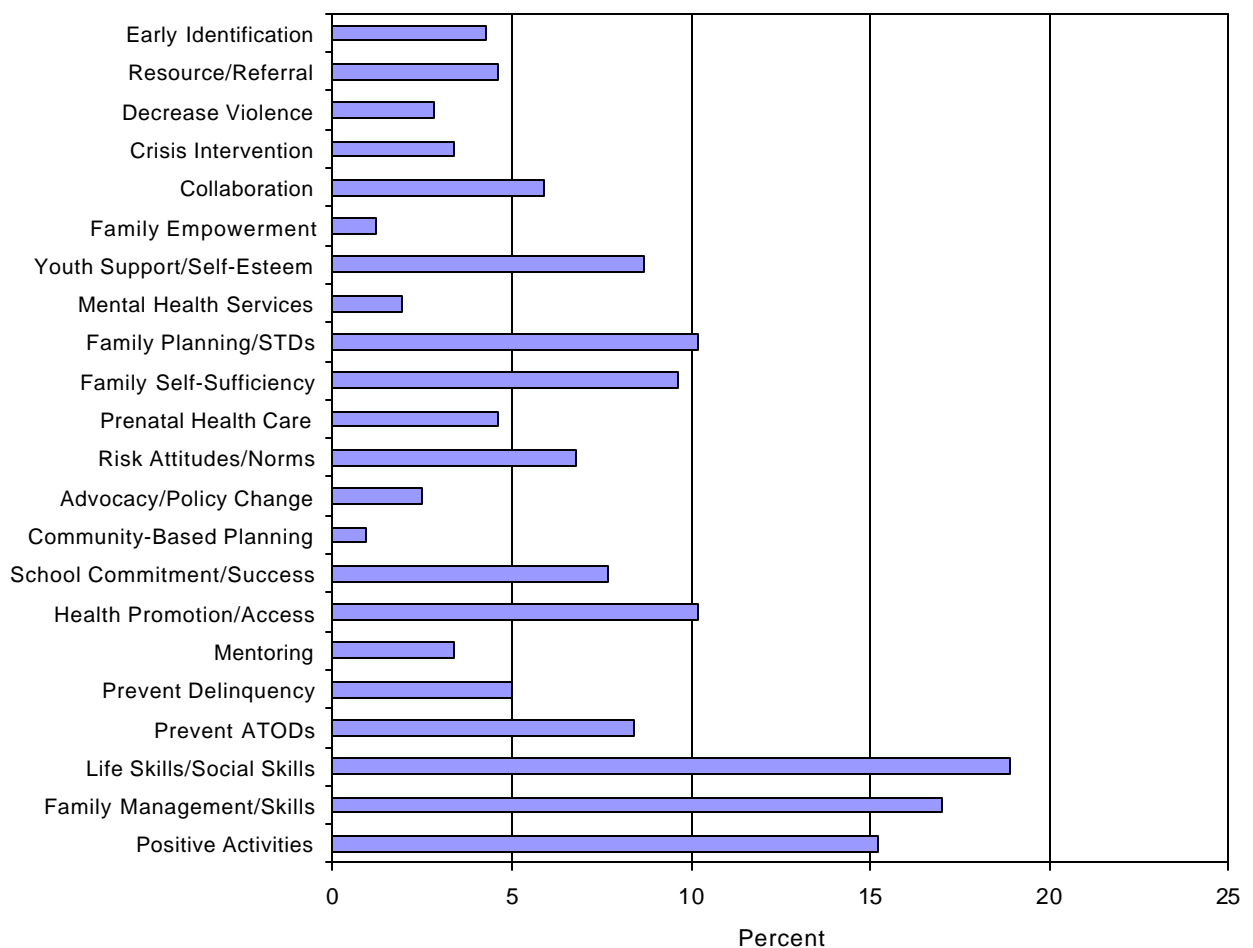
Exhibit 3-24 presents the findings for HPR I. The three most commonly reported foci for programs in HPR I were providing Life Skills/Social Skills Training, Family Management Skills, and Family Planning/STDs. Almost one-fourth of the respondents reported that providing Life Skills/Social Skills Training was a main program focus. Approximately 20 percent of respondents in HPR I reported that providing Family Management Skills was a major program focus. The third most commonly reported program focus was Family Planning/STDs (15.4%), and the forth was providing Positive Alternative Activities (13.8%). All other categories were endorsed by less than 10 percent of respondents.

Exhibit 3-24. Program's Main Focus—HPR I: Phase II Respondents
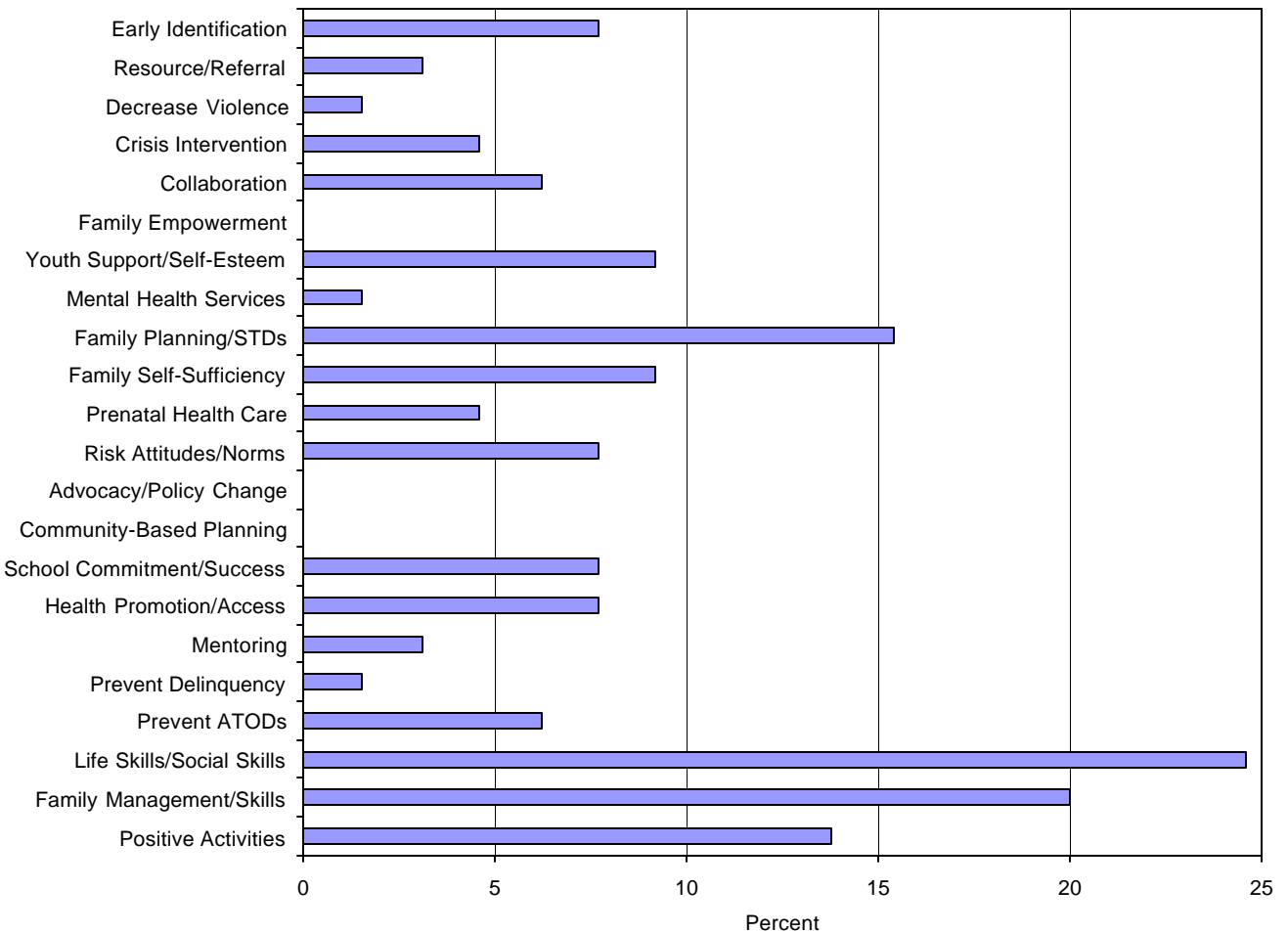
Exhibit 3-25 presents the findings for HPR II. The three most commonly reported program foci in HPR II were Family Management Skills (19.2%), Family Self-Sufficiency (16.4%), and Life Skills/Social Skills Training (15.1%). The fourth most commonly reported programs were Health Promotions/Access (12.3%). Less than 10 percent of respondents reported that the other categories were a main focus of their programs.

Exhibit 3-25. Program's Main Focus—HPR II: Phase II Respondents
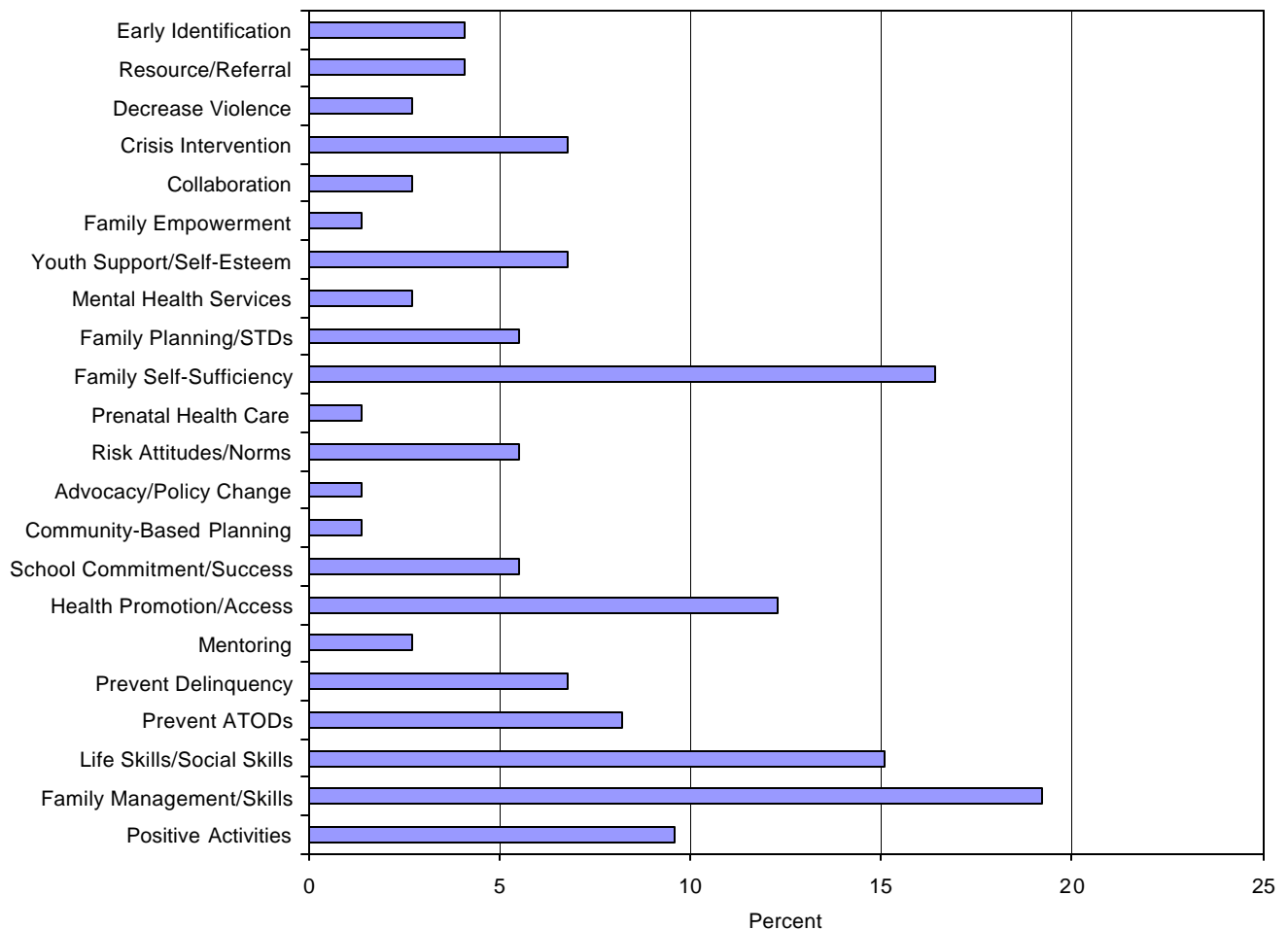
Exhibit 3-26 presents the findings for HPR III. The most common program focus reported by respondents in HPR III was providing Life Skills/Social Skills Training (18.1%) followed by providing Family Management Skills (16%), and Increasing Positive Alternative Activities (13%). Excluding the Prevention of ATOD Use (12.5%) and Providing Youth Support (12.5%), all other categories were endorsed by less than 10 percent of respondents as main program foci in HPR III.

Exhibit 3-26. Program's Main Focus—HPR III: Phase II Respondents
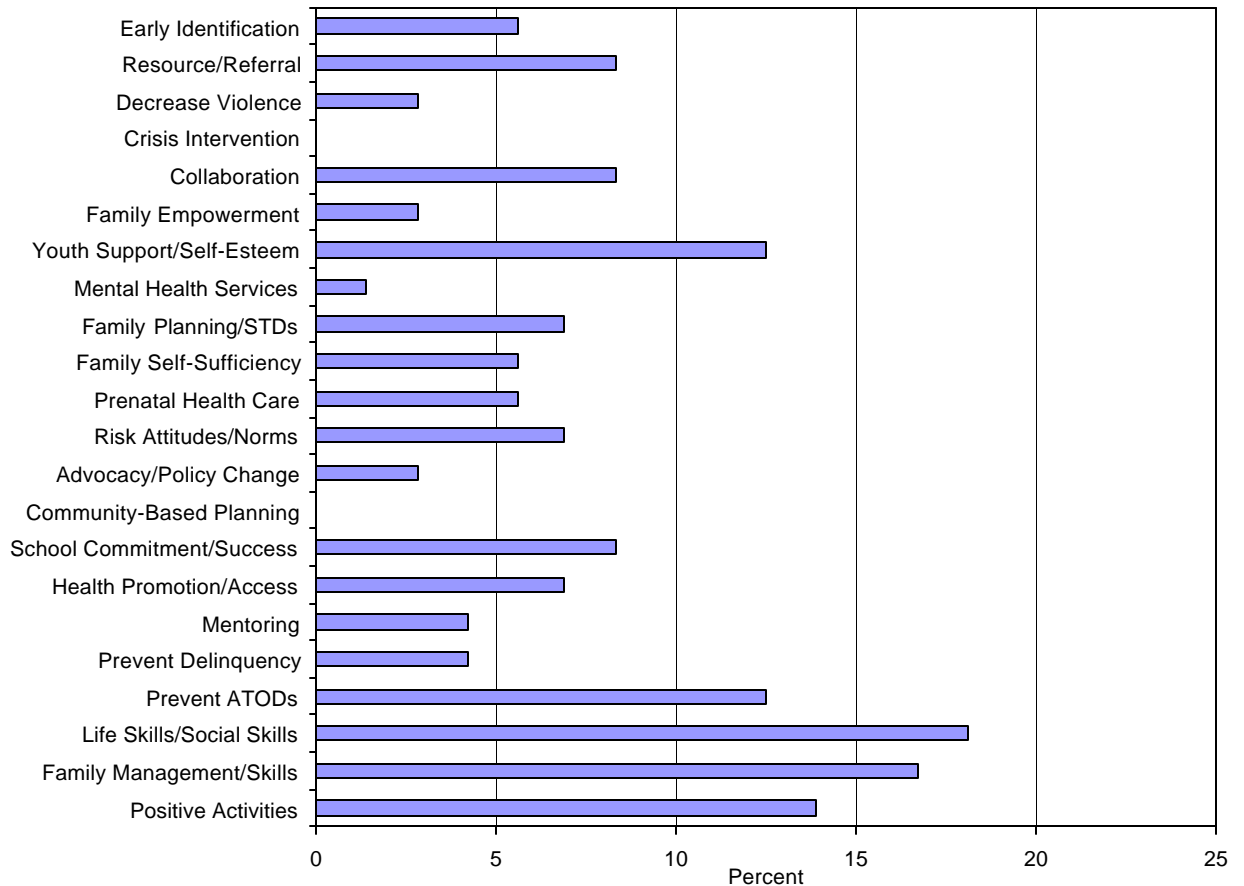
Exhibit 3-27 presents the findings for HPR IV. Almost one-fourth of the respondents reported that Providing Positive Alternative Activities was a main program focus in HPR IV. The second most commonly reported main program focus was providing Life/Social Skills Training (18.3%). Fifteen percent of respondents reported that providing Family Management Skills was a main program focus, the third most commonly reported program focus. Health Promotion (13.3%), Family Self-Sufficiency (11.7%), and Family Planning (11.7%) were reported as a main program focus by slightly more than 10 percent of respondents in HPRIV. All other categories were endorsed by less than 10 percent of the HPR IV respondents.

Exhibit 3-27. Program's Main Focus—HPR IV: Phase II Respondents
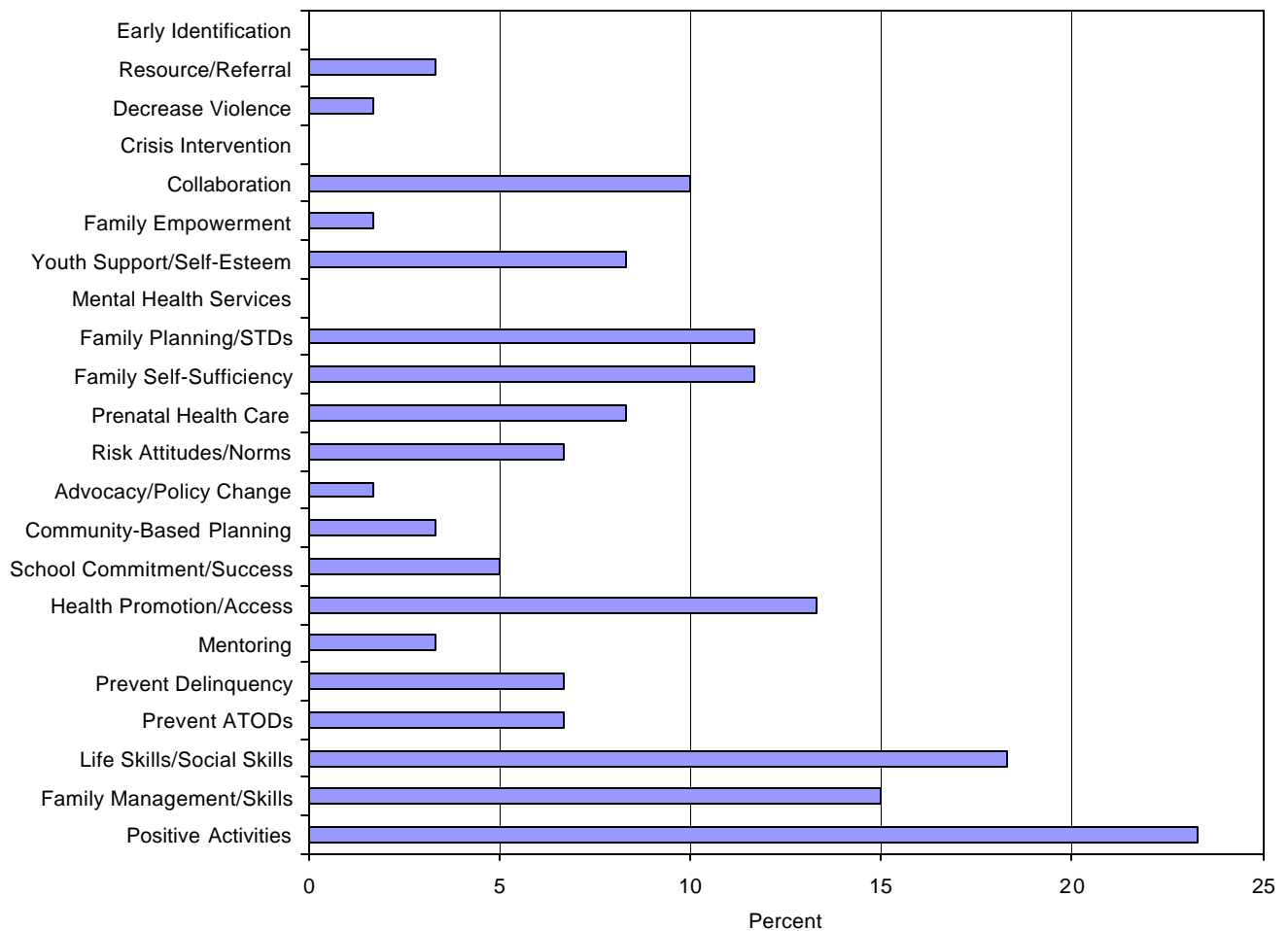
Exhibit 3-28 presents the findings for HPR V. Similar to the other HPRs, the most common program focus reported by HPR V respondents was providing Life/Social Skills Training (20%). Seventeen percent of respondents reported that providing Family Management Skills was a main program focus. The third most commonly reported main program focus was providing Positive Alternative Activities (15.4%). Increasing School Commitment and Family Planning were reported by slightly over 12 percent of respondents as a main focus of their programs. All other categories were endorsed by less than 10 percent of respondents as a main program focus.

Exhibit 3-28. Program's Main Focus—HPR V: Phase II Respondents
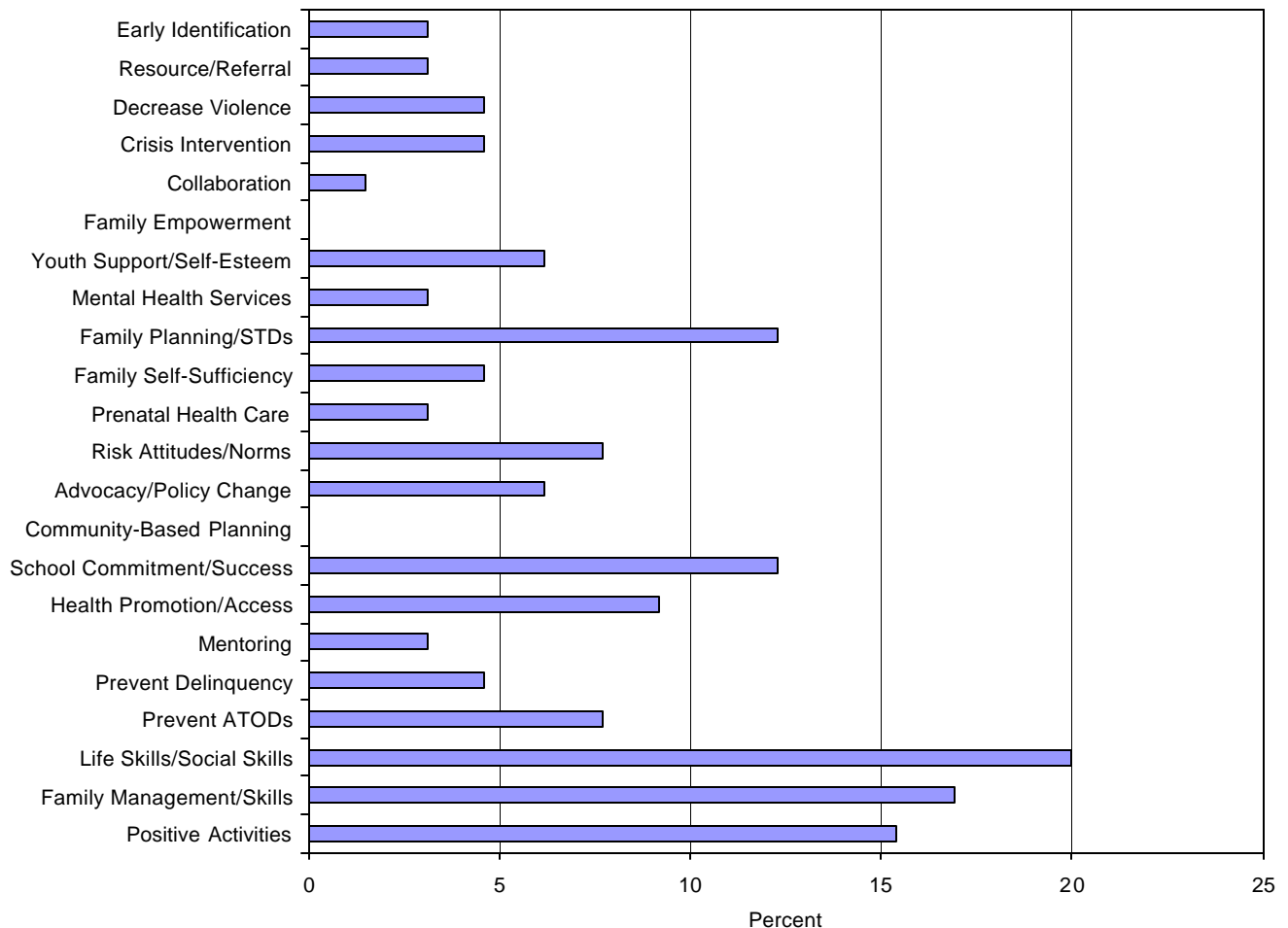
In summary, main program foci reported by respondents were similar across HPRs. In all five HPRs providing Family Management Skills and Life Skills Training were the most commonly reported main program foci. Additionally, in HPRs I, III, IV, and V, providing Positive Alternative Activities was one of the three most common main program foci reported by respondents. Only in HPR II was Family Self-Sufficiency a main program focus, which was one of the three most common responses. It should be noted that only in HPR II was the Prevention of ATOD Use a main program focus reported by more than 10 percent of respondents.

3.2.2.2   *Program Goals and Objectives*

The following section describes the findings from the close-ended questions to which respondents were asked to indicate which of the listed goals and objectives were either (1) a main program focus, (2) addressed, but not a main program focus, and (3) not addressed. The goals and objectives were categorized into the four risk factor domains: peer/individual, family, school, and community.

Peer and Individual Domain

Exhibit 3-29 presents the findings for the Commonwealth. By far, the most common objective that was reported to be a main program focus in the individual and peer domain in the Commonwealth was the *improvement of life/social skills* (51.0%). In fact, 87.1 percent of respondents indicated that the *improvement of social skills* was at least addressed by their program.

Exhibit 3-29. Commonwealth Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
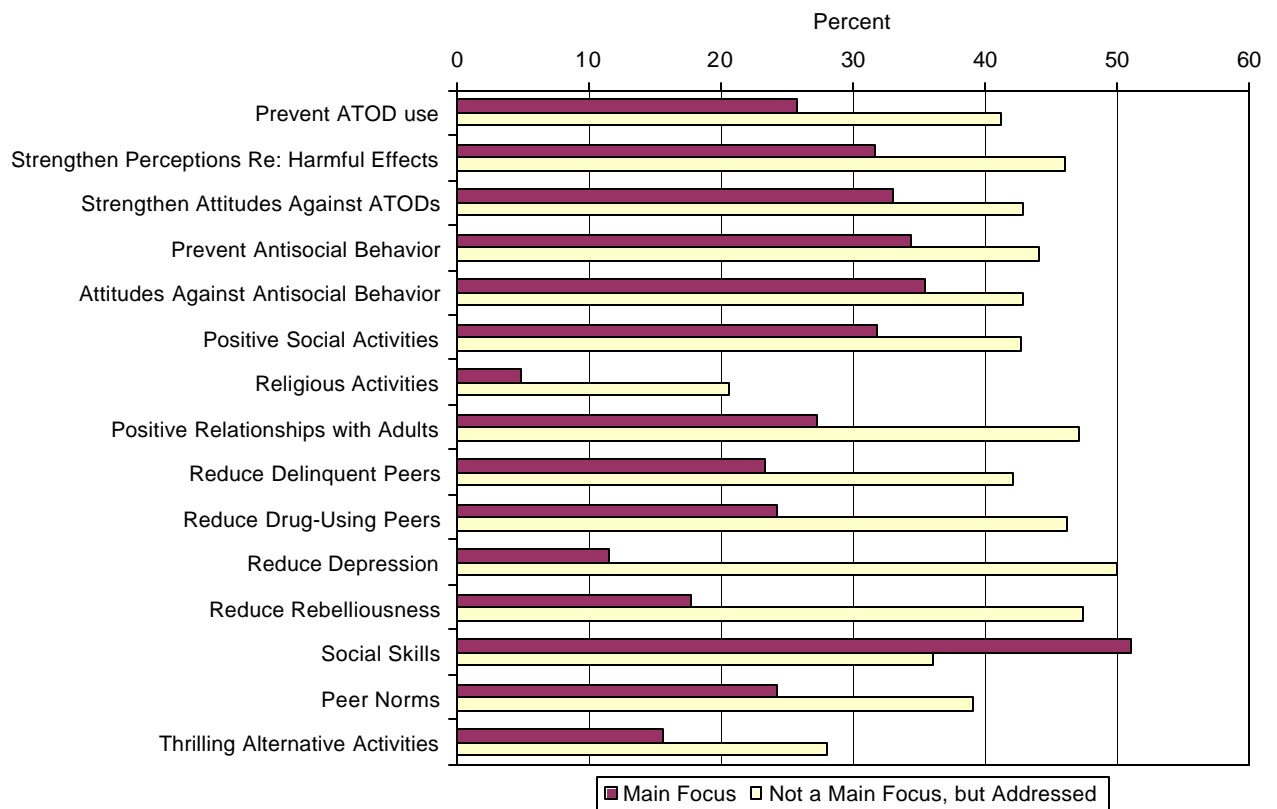
Following the *improvement of social skills,* a cluster of five objectives were the second most commonly reported objectives. These objectives include the following:

- *Strengthening attitudes against anti-social behaviors* (35.5%);

- *Preventing antisocial behaviors* (34.4%);

- *Strengthening attitudes against ATOD use* (33.0%);

- *Increasing involvement in positive social activities* (31.8%); and

- *Strengthening perceptions about negative effects of ATOD use* (31.7%).

A relatively rare objective was *increasing involvement in religious activities* (4.9%). Indeed, 75 percent of respondents indicated that this was not addressed at all as an objective of their programs.

Exhibit 3-30 presents the findings for HPR I. Similar to results of the Commonwealth, the most common objective reported to be a main program focus in the individual and peer domain in HPR I was *improving social skills.* Fifty-five percent of respondents reported that *improving social skills* was a main program objective in HPR I.

Exhibit 3-30. HPR I Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
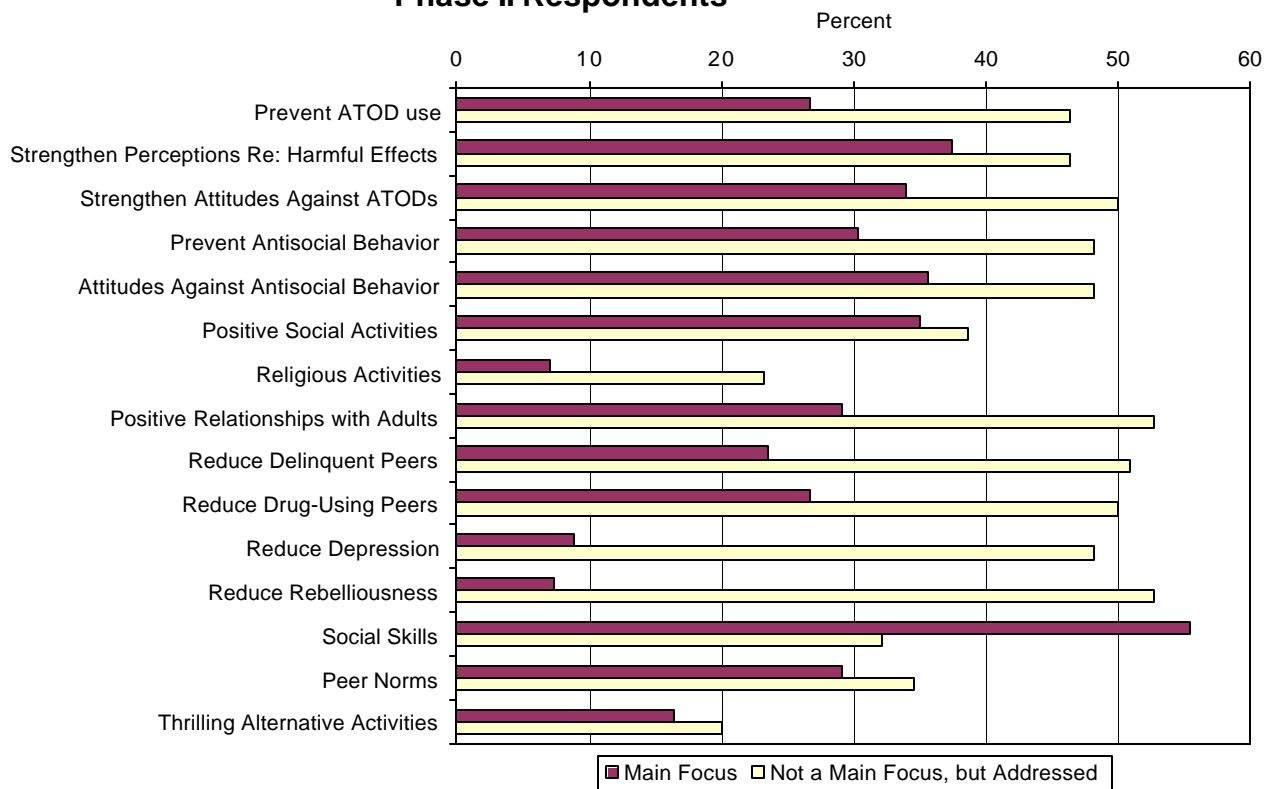
A cluster of five objectives for which approximately one-third of respondents reported as main program objectives are the second most commonly reported objectives in HPR I. These objectives include:

- *Strengthening perceptions about negative effects of ATOD use* (37.5%);

- *Strengthening attitudes against antisocial behaviors* (35.7%);

- *Increasing involvement in positive social activities* (35.1%);

- *Strengthening attitudes against ATOD use* (33.9%); and

- *Preventing antisocial behaviors* (30.4%).

By far, *increasing involvement in religious activities* and *reducing rebelliousness* were the least common objectives reported by respondents (7.1%).

Exhibit 3-31 presents the findings for HPR II. In HPR II, the most commonly reported objective was *improving social skills* (50%). The following four objectives were reported to be a main program focus by approximately one-third of respondents in the individual/peer domain in HPR II:

- *Preventing antisocial behaviors* (37.5%);

- *Strengthening attitudes against antisocial behaviors* (31.3%);

- *Strengthening attitudes against ATOD use* (30.2%); and

- *Providing positive alternative activities* (30.2%).

Exhibit 3-31. HPR II Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
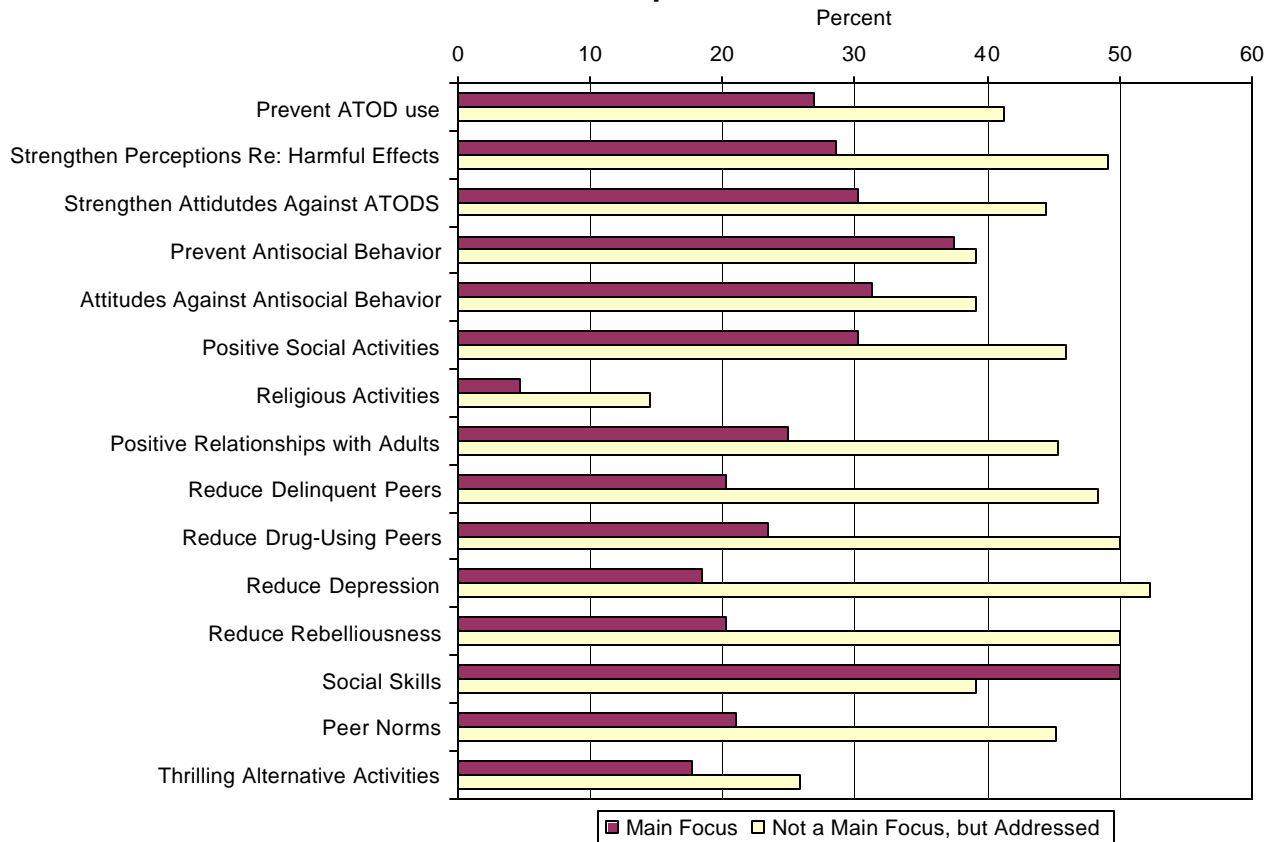
Only 5 percent of respondents reported that *increasing participation in religious activities* was a main objective.

Exhibit 3-32 presents the findings in HPR III. In HPR III, *improving social skills* was the most commonly reported program objective (60.6%). In HPR III, a larger percentage of respondents endorsed main program objectives in the individual/peer domain. Seven objectives in the individual/peer domain were reported by more than one-third of respondents to be a main focus of their programs:

- *Strengthening attitudes against anti-social behaviors* (43.5%);

- *Strengthening perceptions about harmful effects of ATOD use* (40.6%);

- *Preventing antisocial behaviors* (40.6%);

- *Strengthening attitudes against ATOD use* (39.1%);

- *Prevent or delay first use of ATODs* (34.8%);

- *Increase youth awareness of peer norms opposed to ATOD use* (32.9%); and

- *Increasing involvement in positive social activities* (31.3%).

Exhibit 3-32. HPR III Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
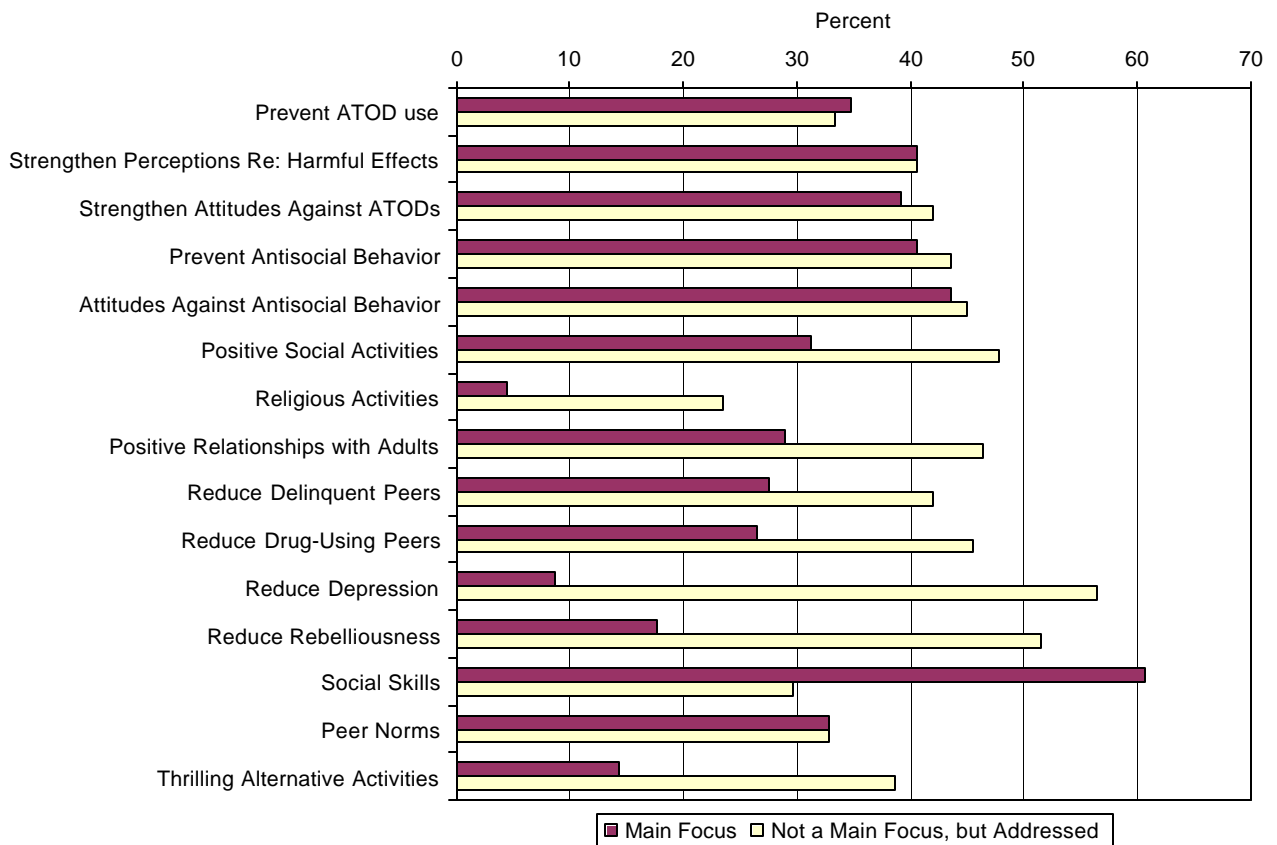
Less than 10 percent of respondents reported that *reducing depression* (8.7%) and *increasing involvement in religious activities* (4.4%) were main program foci.

Exhibit 3-33 presents the findings for HPR IV. In HPR IV, the most commonly reported objective was *increasing social skills* (54.7%). Six objectives in the individual/peer domain were reported by over one-third of respondents to be a main focus of their programs, including:

- *Strengthening attitudes against ATOD use* (39.6%);

- *Preventing antisocial behaviors* (36.7%);

- *Increasing involvement in positive social activities* (36.7%);

- *Strengthening attitudes against antisocial behaviors* (35.4%);

- *Strengthening perceptions about negative effects of ATOD use* (34.7%); and

- *Increase number of youth who have positive relationships with adults* (34.6%).

Less than 10 percent of respondents reported that *decreasing depression* (6%) and *increasing involvement in religious activities* (4.1%) was a main program focus.

Exhibit 3-33. HPR IV Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
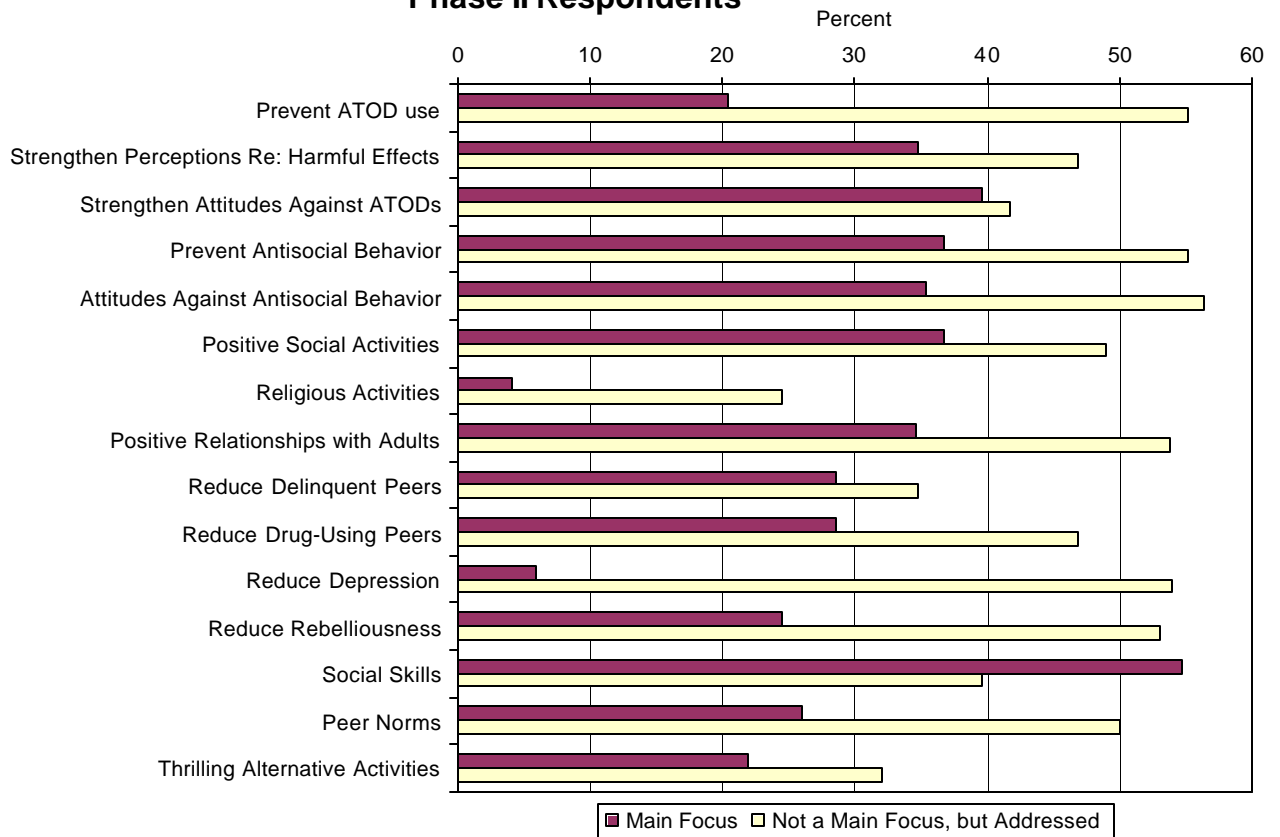
Exhibit 3-34 presents the findings for HPR V. In HPR V, *increasing social skills* (41.9%) was the most common objective reported to be a main program focus. Only one objective was reported to be a main focus by over one-third of respondents: *strengthening attitudes against antisocial behavior* (36.1%). The least common objective was *increasing involvement in religious activities* (4.8%).

Exhibit 3-34. HPR V Program Goals and Objectives—Peer/Individual Domain: Phase II Respondents
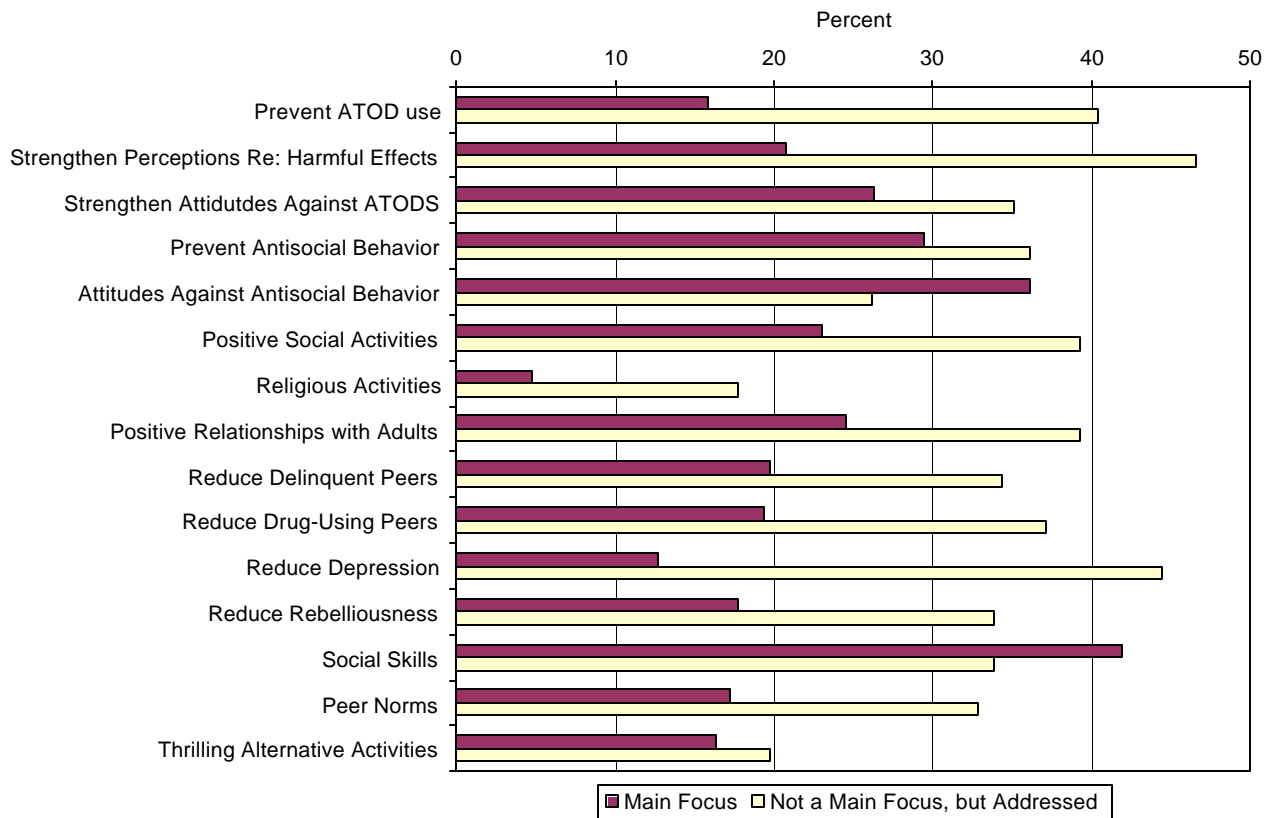
In summary, the most common objective reported to be a main program focus across all five HPRs was *increasing social skills*, whereas the least common objective across all five HPRs was *increasing involvement in religious activities*.

Family Domain

Exhibit 3-35 presents the findings for the Commonwealth. In the family domain, there were no objectives that were endorsed by more than half of the respondents as a main focus of their program. The two most common objectives reported to be not a main focus, but addressed were *improving family communication skills* (39.7%) and *improving family management skills* (35.4%). The third most common objective reported by respondents as a main program objective was *improving parents' ability for pro-social family involvement* (31.7%). Interestingly, the least common program objective reported by respondents was *reducing ATOD use in family members* (8.9%). However, over 45 percent of respondents reported that although *reducing ATOD use in families* was not a main program focus, it was addressed in their programs.

Exhibit 3-35. Commonwealth Program Goals and Objectives—Family Domain: Phase II Respondents
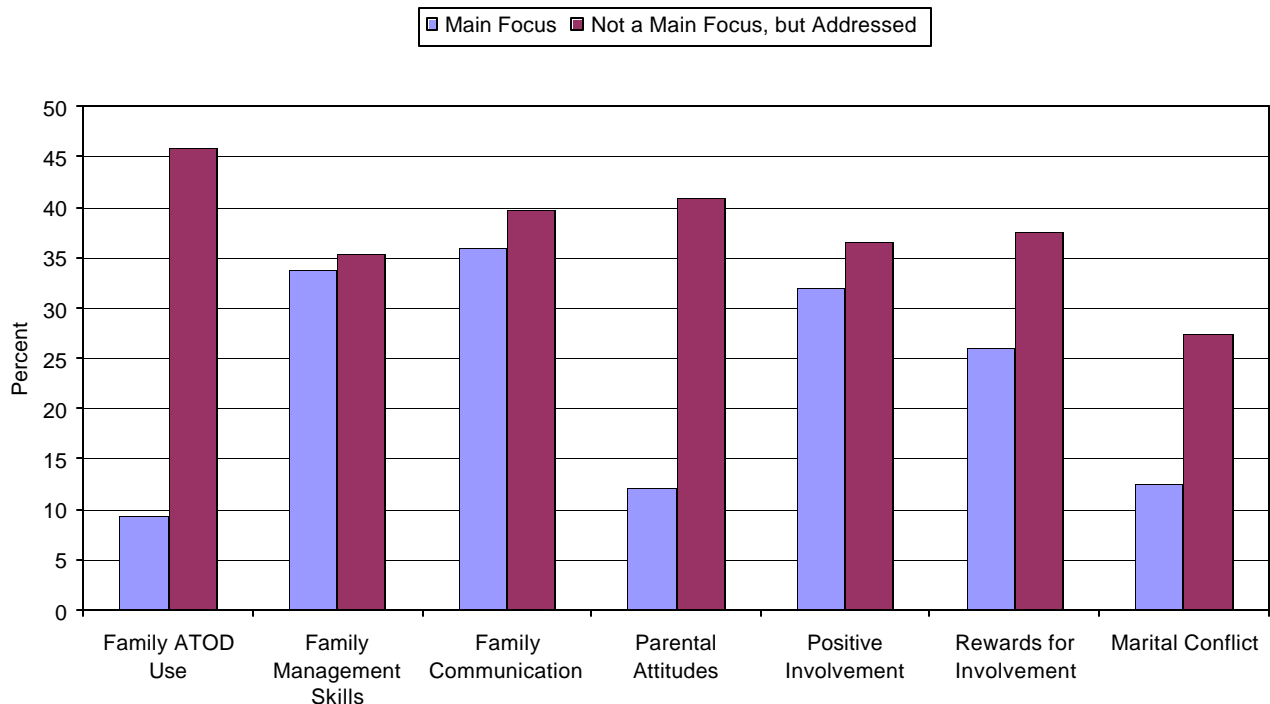
Exhibit 3-36 presents the findings for HPR I. In HPR I, the most common objective was *improving parents' ability for pro-social family involvement* (29.1%). The second most commonly reported main program objective in the family domain was *improving family management skills* (26.8%), followed closely by *improving family communication skills* (26.3%). It should be noted that less than 30 percent of respondents endorsed any of the objectives in the family domain as being a main program focus.

**Exhibit 3-36. HPR I Program Goals and Objectives—Family Domain:
Phase II Respondents**

◻ Main Focus ◼ Not a Main Focus, but Addressed
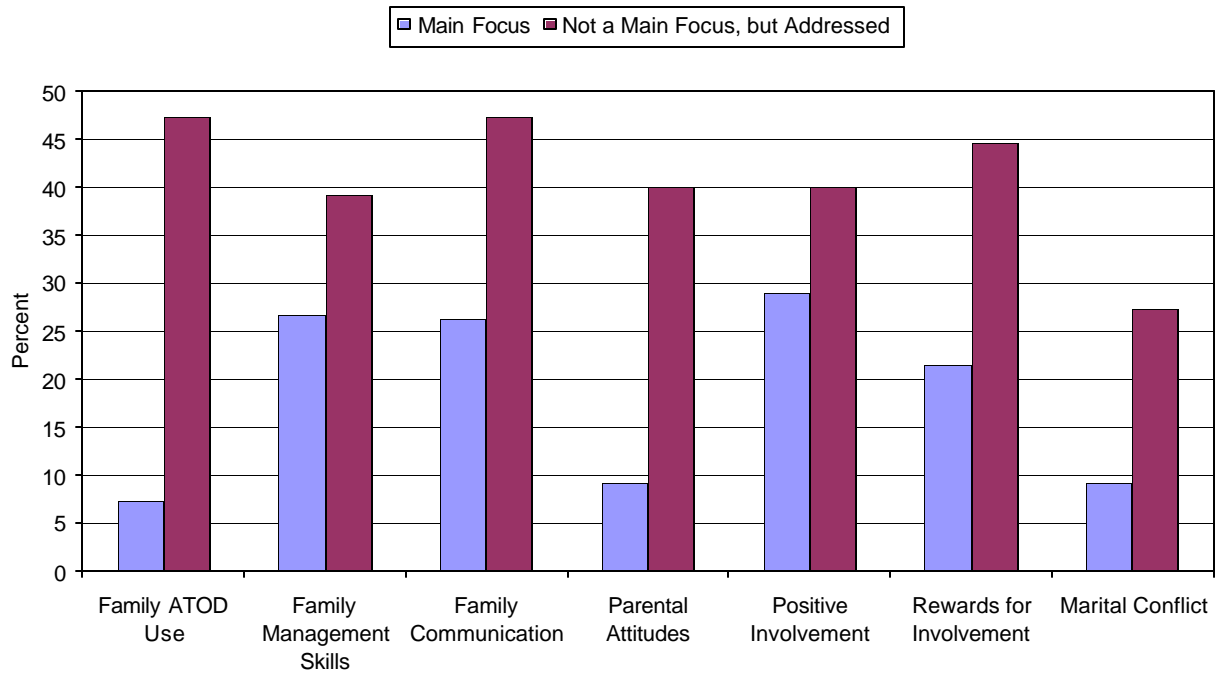
Exhibit 3-37 presents the findings for HPR II. In HPR II, the most common objective was *improving parents' ability for pro-social family involvement* (35.9%), followed by *increasing parental ability to reward positive family involvement* (31.7%) and *increasing family communication* (29.7%).

**Exhibit 3-37. HPR II Program Goals and Objectives—Family Domain:
Phase II Respondents**

◻ Main Focus ◼ Not a Main Focus, but Addressed
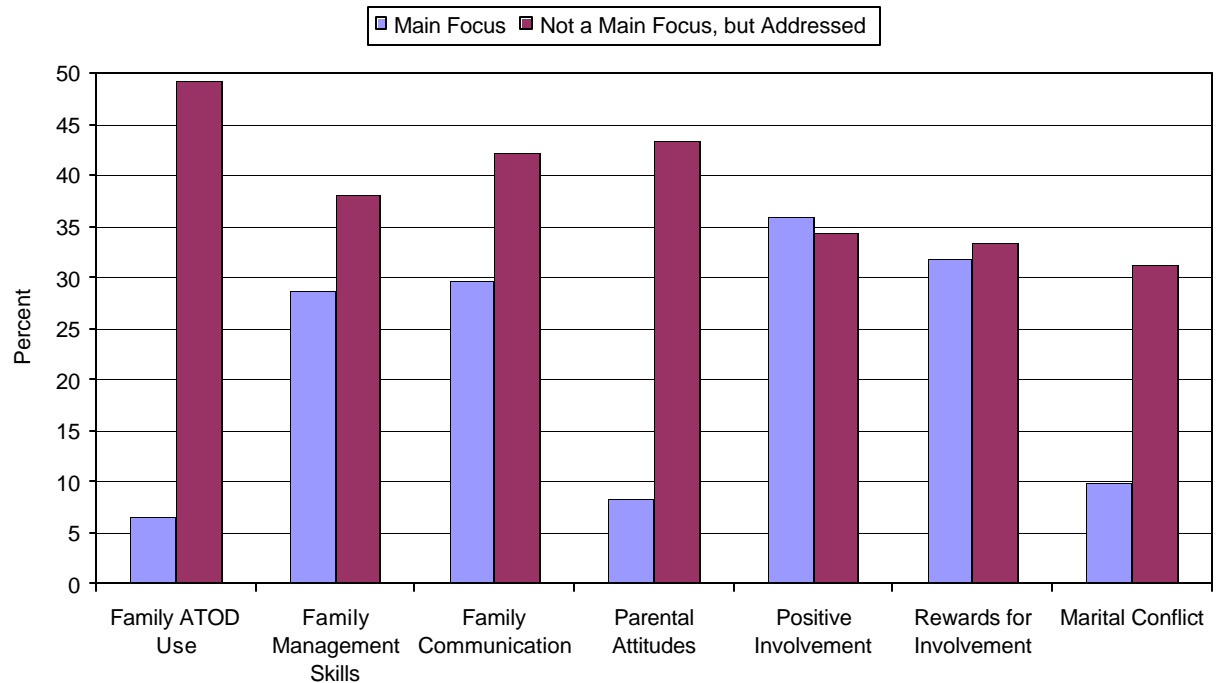
Exhibit 3-38 presents the findings for HPR III. *Improving family communication skills* was the most commonly reported objective in HPR III (45%), followed by *improving family management skills* (38.6%) and *improving positive involvement* (34.3%).

Exhibit 3-38. HPR III Program Goals and Objectives—Family Domain:
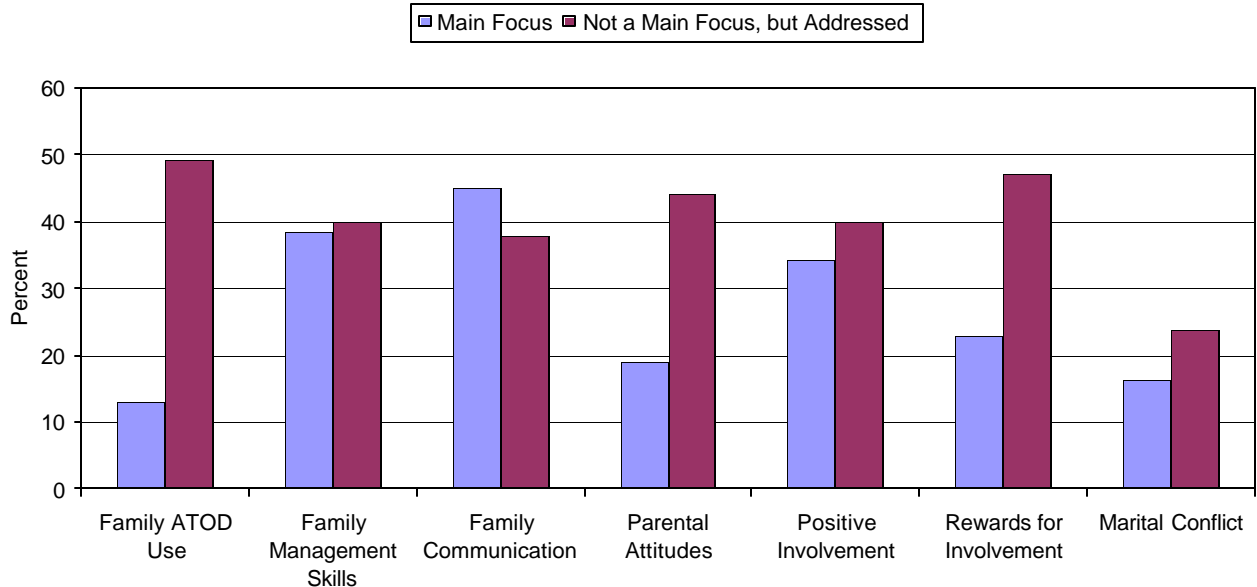
Phase II Respondents

Exhibit 3-39 presents the findings for HPR IV. The most commonly reported main objective in HPR IV was *improving family communication skills* (45%), followed by improving *family management skills* (42%) and *improving positive involvement* (35.3%)

Exhibit 3-39. HPR IV Program Goals and Objectives—Family Domain: Phase II Respondents
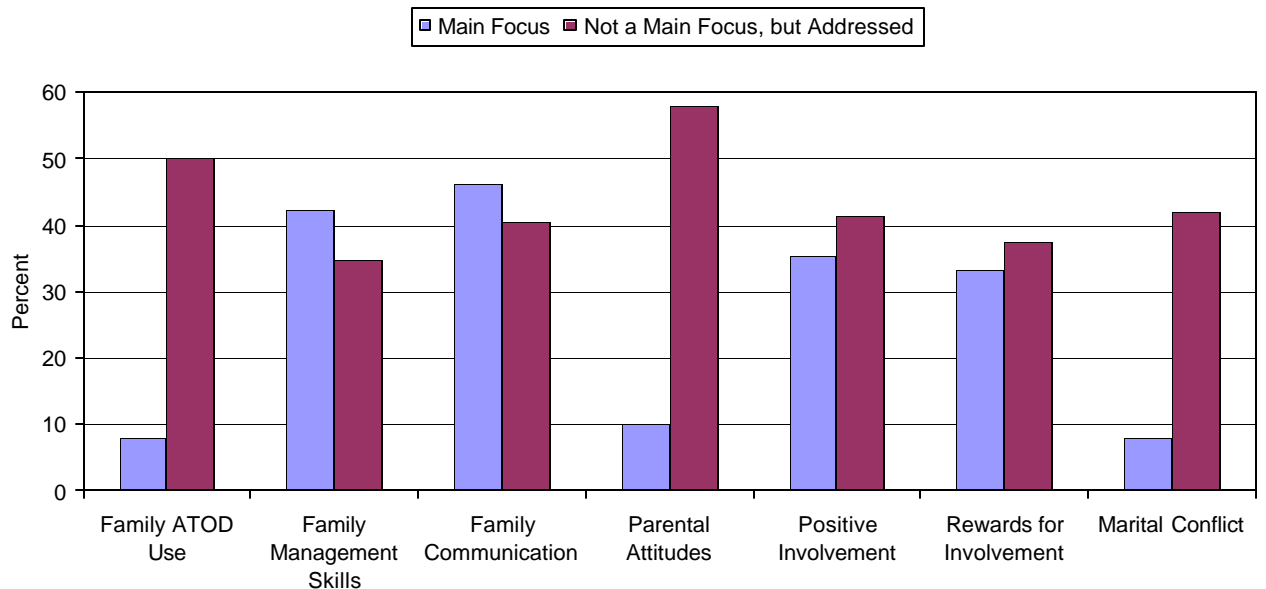
Exhibit 3-40 presents the findings for HPR V. The most commonly reported objective in HPR V was *improving family management skills* (28.8%). The second most commonly reported objective by respondents in HPR V was *improving family communication skills* (28.3%), followed by *improving positive involvement* (23.3%). It should be noted that less than 30 percent of all respondents in HPR V reported that objectives in the family domain were main program foci.

Exhibit 3-40. HPR V Program Goals and Objectives—Family Domain:
Phase II Respondents
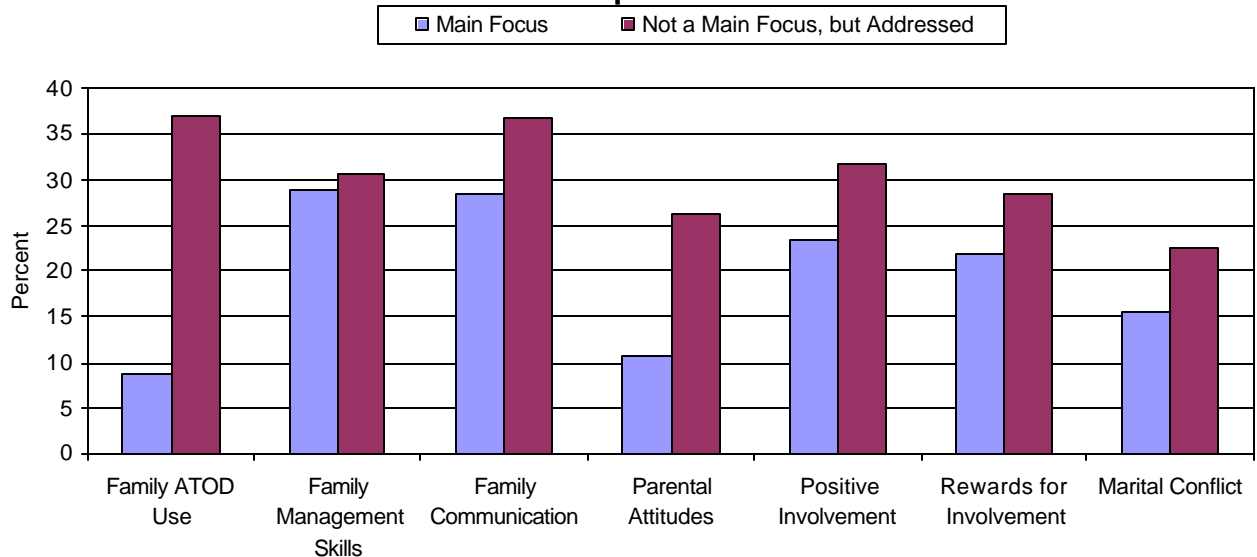
School Domain

Exhibit 3-41 presents the findings for the Commonwealth. In the Commonwealth, less than one-third of all respondents reported that program objectives in the school domain were a main focus of their programs. The most commonly reported objective was *increasing opportunities for pro-social involvement in the schools* (29.4%), followed by *increasing school commitment* (29%) and *improving academic skills* (22.9%).

Exhibit 3-41. Commonwealth Program Goals and Objectives—School Domain: Phase II Respondents
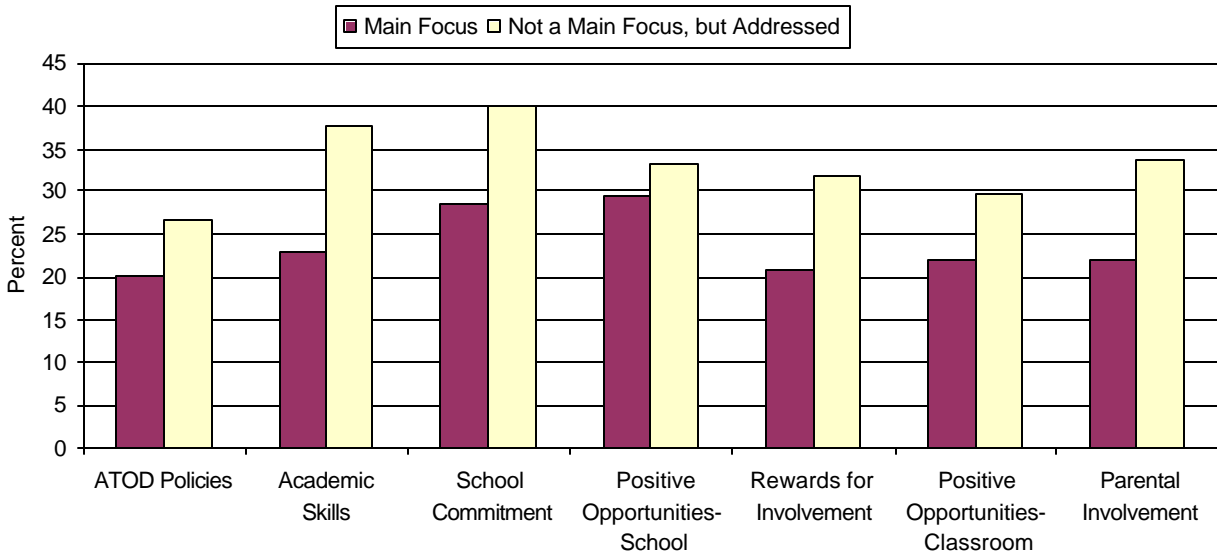
Exhibit 3-42 presents the findings for HPR I. Similar to the Commonwealth findings, less than one-third of the respondents reported that program objectives in the school domain in HPR I were a main focus of their programs. The most common objective reported by respondents in HPR I was *increasing opportunities for positive youth participation* in the schools (26%), followed by *increasing school commitment* (25.5%), which was endorsed by approximately one-fourth of the respondents, and improving academic skills (23.2%).

Exhibit 3-42. HPR I Program Goals and Objectives—School Domain: Phase II Respondents
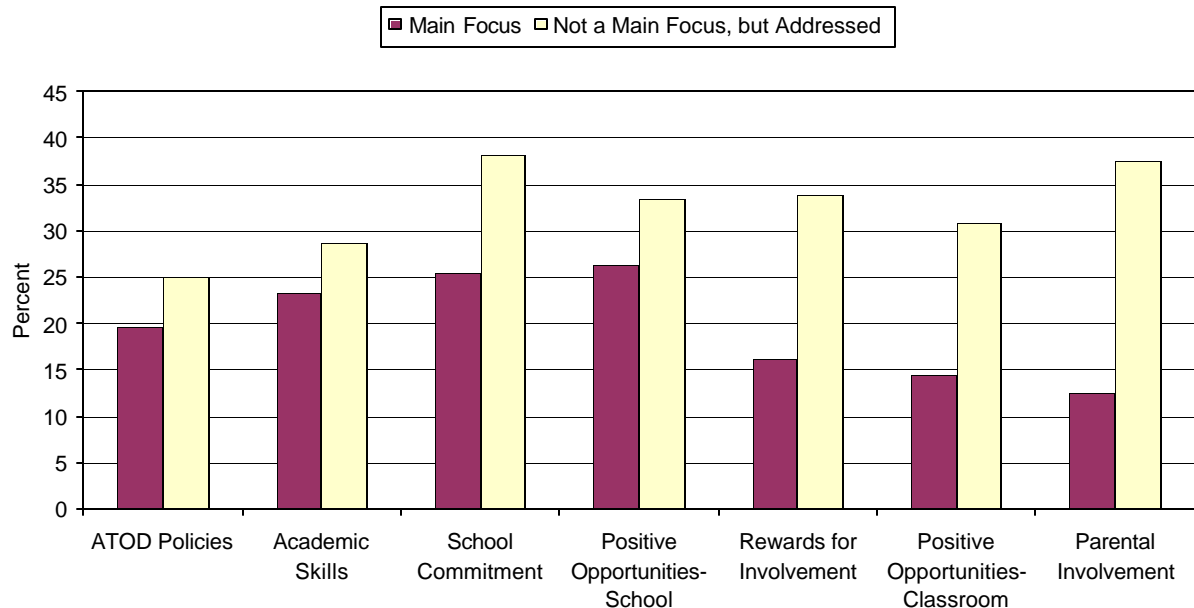
Exhibit 3-43 presents the findings for HPR II. Similar to the findings obtained from the Commonwealth, less than one-third of the respondents reported that program objectives in the school domain in HPR II were a main focus of their programs. The most commonly reported objectives were *increasing school commitment* (28.3%) and *increasing opportunities for positive school involvement* (28.3%), followed by *increasing opportunities for classroom involvement* (24.2%) and *increasing parental involvement* (23.3).

Exhibit 3-43. HPR II Program Goals and Objectives—School Domain: Phase II Respondents
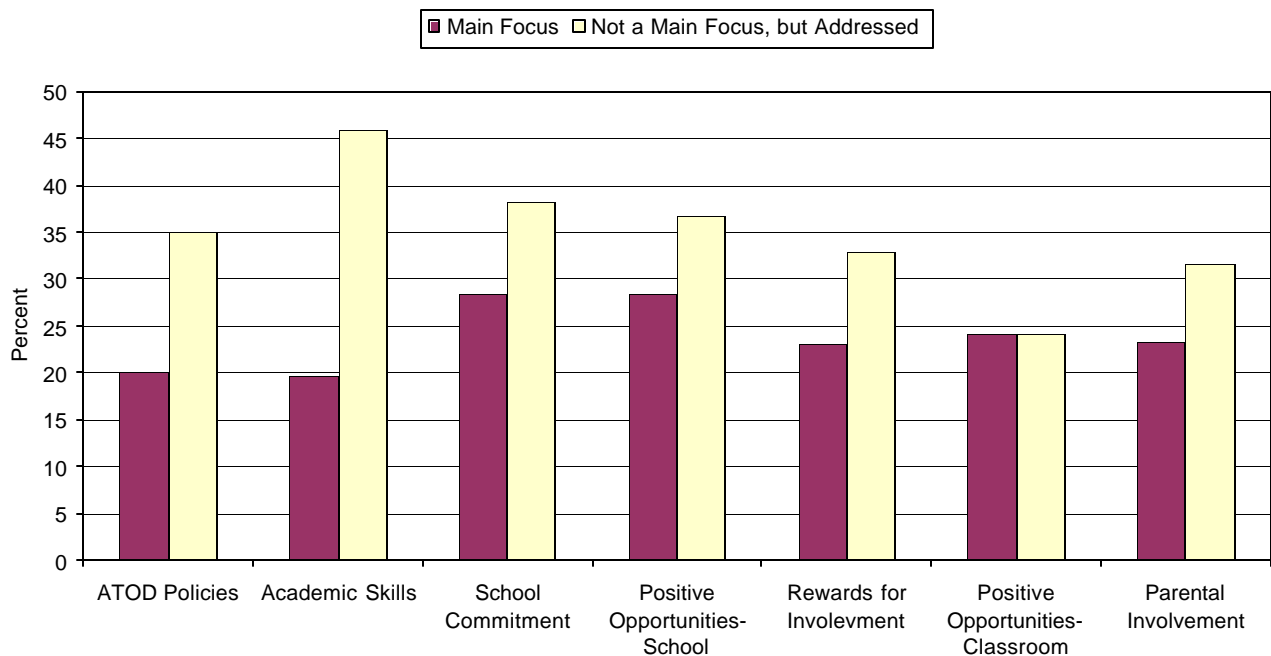
Exhibit 3-44 presents the findings for HPR III. Similar to the Commonwealth findings, less than one-third of the respondents reported that program objectives in the school domain were a main focus of their programs in HPR III. Again, the most commonly reported objective was *increasing opportunities for positive school involvement* (29%), followed by *increasing school commitment* (28%) and *increasing parental involvement* (23%).

Exhibit 3-44. HPR III Program Goals and Objectives—School Domain: Phase II Respondents
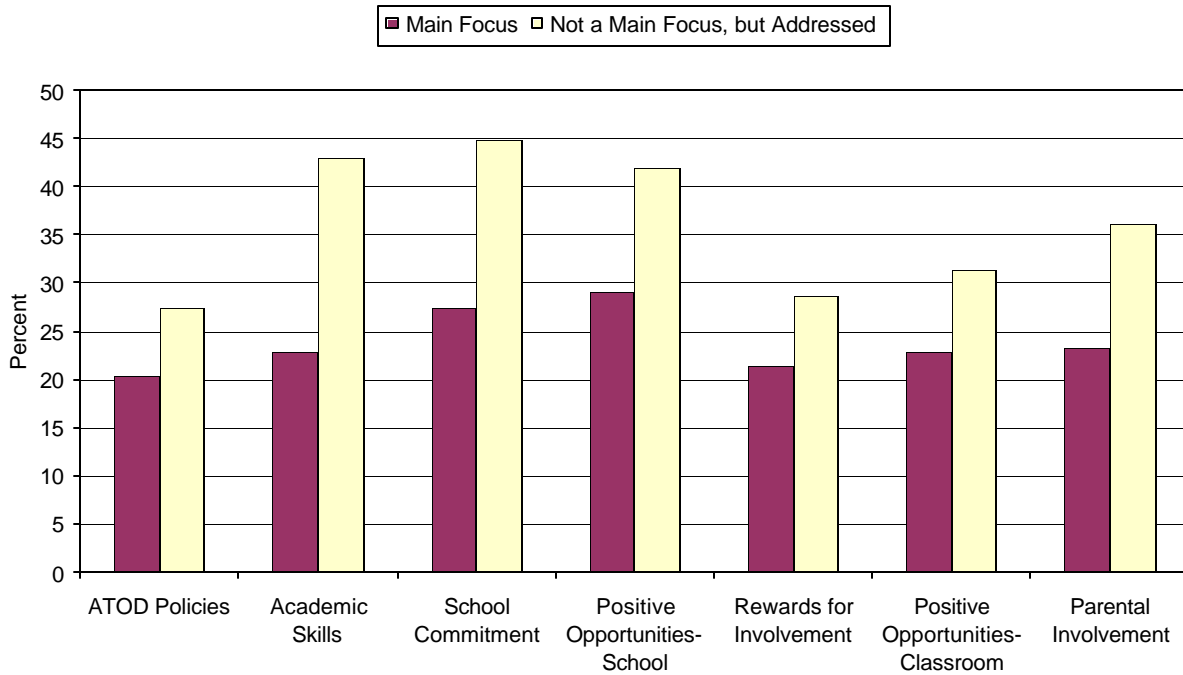
Exhibit 3-45 presents the findings for HPR IV. More respondents in HPR IV were likely to report that objectives in the school domain were a main program focus compared to the other HPRs. Almost half of respondents reported that *increasing opportunities for positive school involvement* was a main program objective. The second most commonly reported main program objective in HPR V was *increasing school commitment* (38.5%), followed closely by *increasing parental involvement in school activities* (37%).

Exhibit 3-45. HPR IV Program Goals and Objectives—School Domain: Phase II Respondents
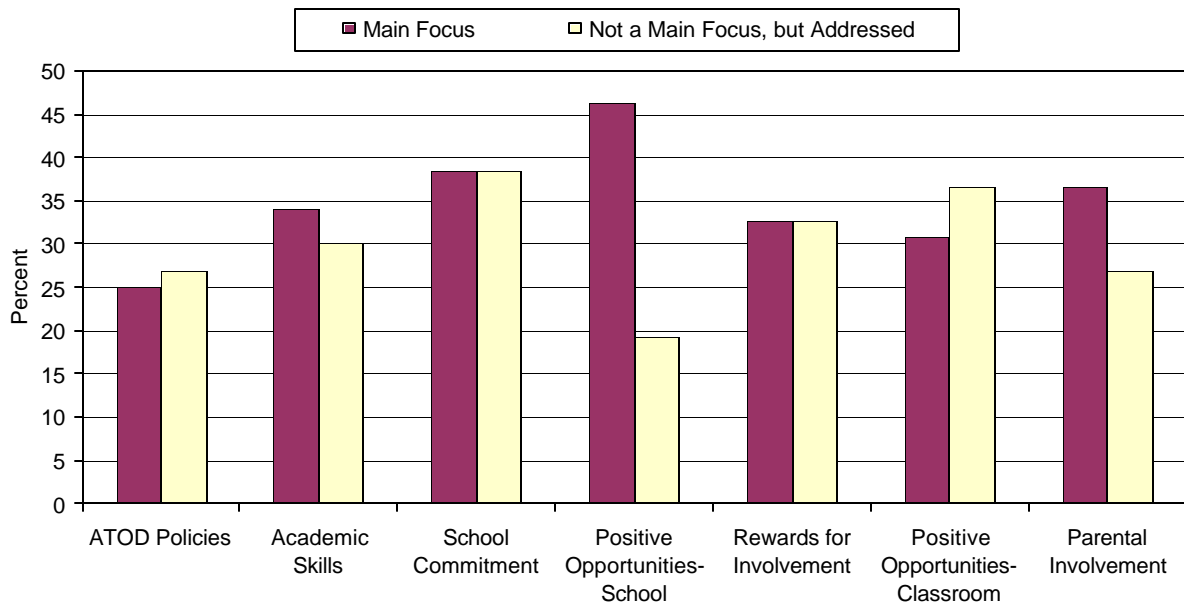
Exhibit 3-46 presents the findings for HPR V. Similar to the Commonwealth, less than one-third of respondents reported that program objectives in the school domain in HPR V were a main focus of their programs. The most commonly reported objective was *increasing school commitment* (22%). The second most commonly reported main program objective was *increasing positive opportunities for school involvement* (16.1%), followed by *increasing positive opportunities for classroom involvement* (14.8%).

Exhibit 3-46. HPR V Program Goals and Objectives—School Domain: Phase II Respondents
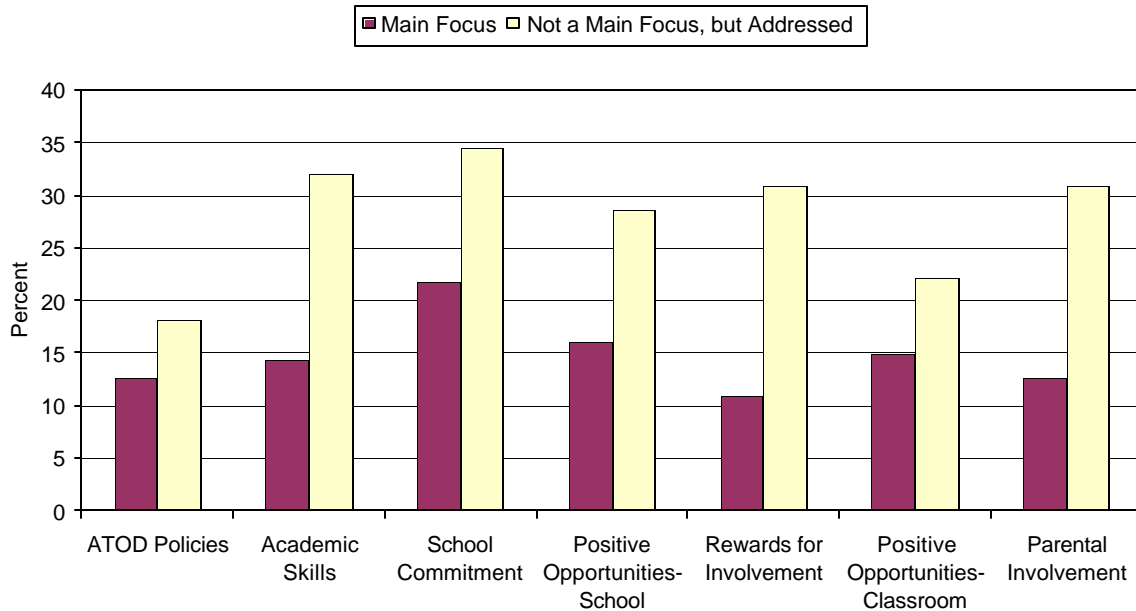
In summary, the most common objective reported for HPRs I, II, III, and IV was *increasing opportunities for positive school involvement.* In HPR V the most common objective reported was *increasing school commitment.*

The least common objective varied by HPR. In HPR I, the least common objective was *increasing positive parental involvement* (12.5%). In HPR II, the least common objective reported was *improving academic skills* (19.4%). In HPRs III and IV, the least common objective was *establishing, communicating and enforcing policies regarding ATOD use* (20.6 percent and 25.0 percent, respectively). In HPR V, the least common objectives was *increasing rewards for positive youth participation in the classroom* (10.9%).

Community Domain

Exhibit 3-47 presents the findings for the Commonwealth. Less than one-fourth of all respondents indicated that program objectives in the community domain were a main focus of their programs. The most commonly reported objective was *increasing opportunities for positive youth involvement in the community* (23.5%). *Developing and strengthening community laws that restrict ATOD use* (10.1%) and *improving adjustment to transitions to a new home or school* (10.4%) were the least common objectives reported.

Exhibit 3-47. Commonwealth Program Goals and Objectives—Community Domain: Phase II Respondents
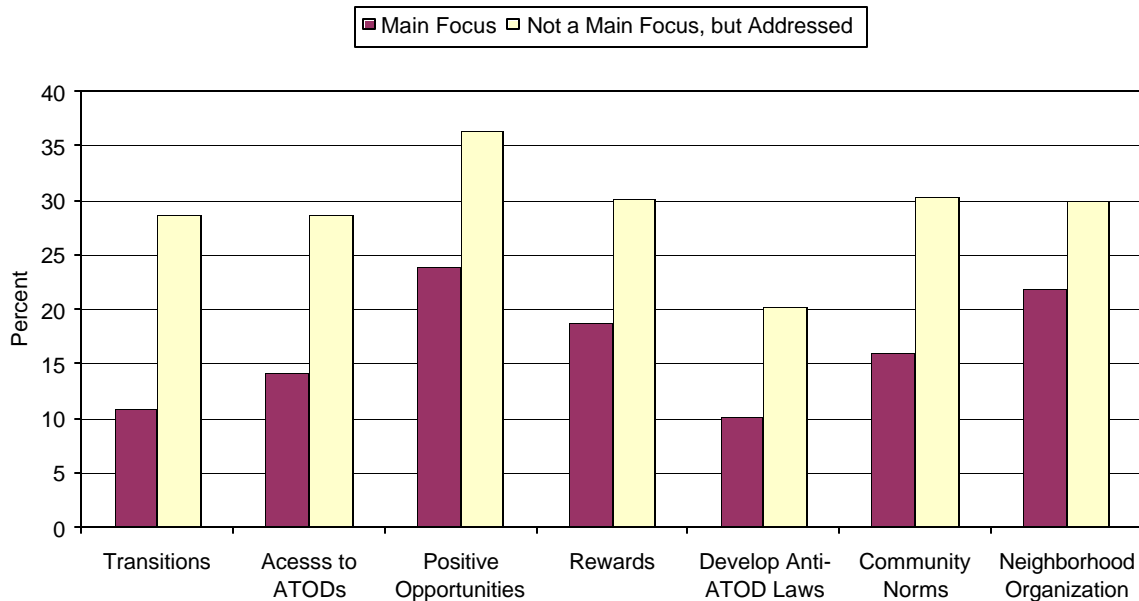
Exhibit 3-48 presents the findings for HPR I. Similar to the Commonwealth, one-fourth or less of the respondents in HPR I indicated that objectives in the community domain were a main focus of their programs. The most common objective in HPR I was *increasing opportunities for positive youth involvement in the community* (25.0%). The second most commonly reported main program objective was *strengthening community norms and/or attitudes against ATOD use* (23.2%). The least common objective was *transitioning to a new home or school* (7.4%).

Exhibit 3-48. HPR I Program Goals and Objectives—Community Domain: Phase II Respondents
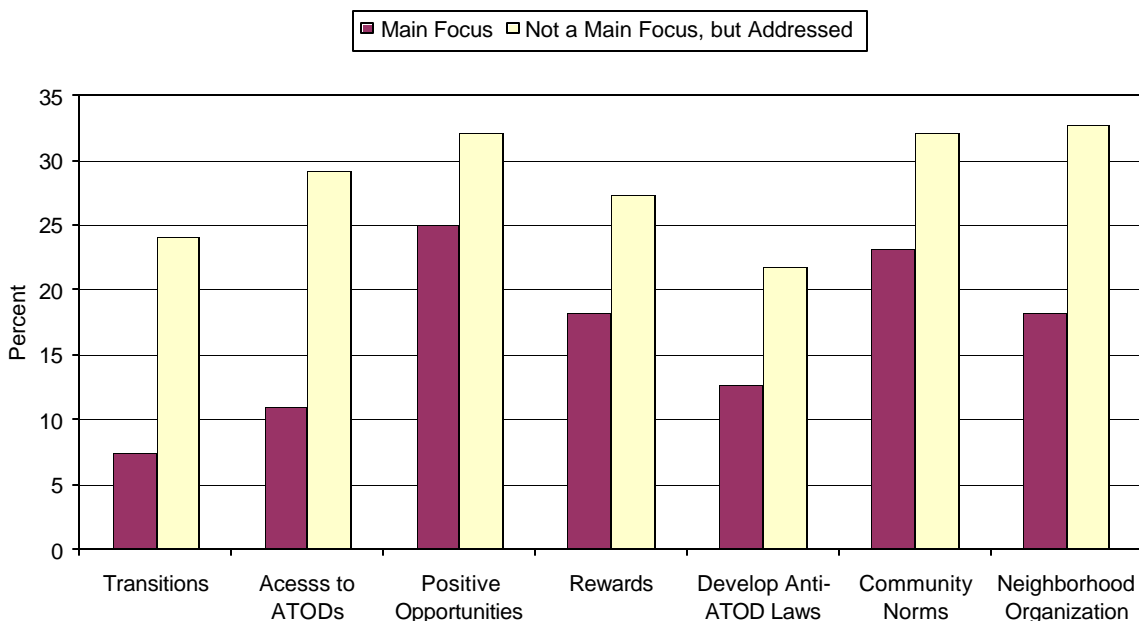
Exhibit 3-49 presents the findings for HPR II. The most commonly reported objective in the community domain in HPR II was *increasing rewards for positive involvement in the community* (31%), followed by *increasing positive opportunities for youth involvement in the community* (29.5%) and increasing neighborhood organization (22%).

Exhibit 3-49. HPR II Program Goals and Objectives—Community Domain: Phase II Respondents
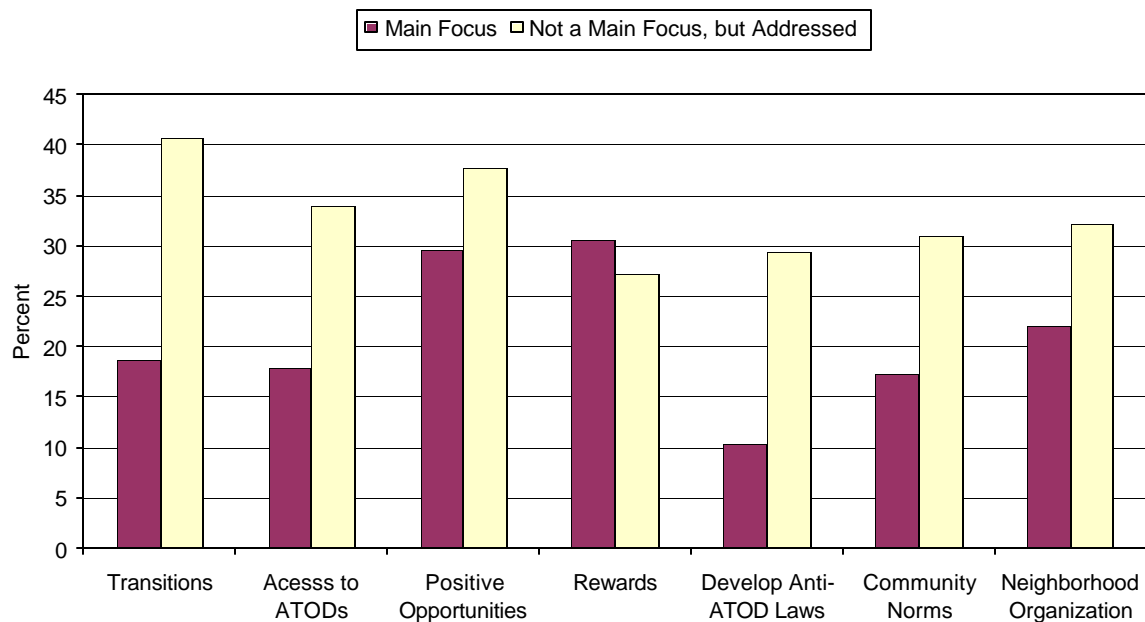
Exhibit 3-50 presents the findings for HPR III. Similar to the Commonwealth, one-fourth or less of the respondents in HPR III indicated that objectives in the community domain were a main focus of their programs. The most commonly reported objective in HPR III was *improving neighborhood safety, organization, or sense of community* (20.9%), followed by *increasing positive opportunities for youth involvement in the community* (18.8%) and *increasing rewards for positive youth involvement in the community* (17.9%).

Exhibit 3-50.
HPR III Program Goals and Objectives—Community Domain: Phase II Respondents
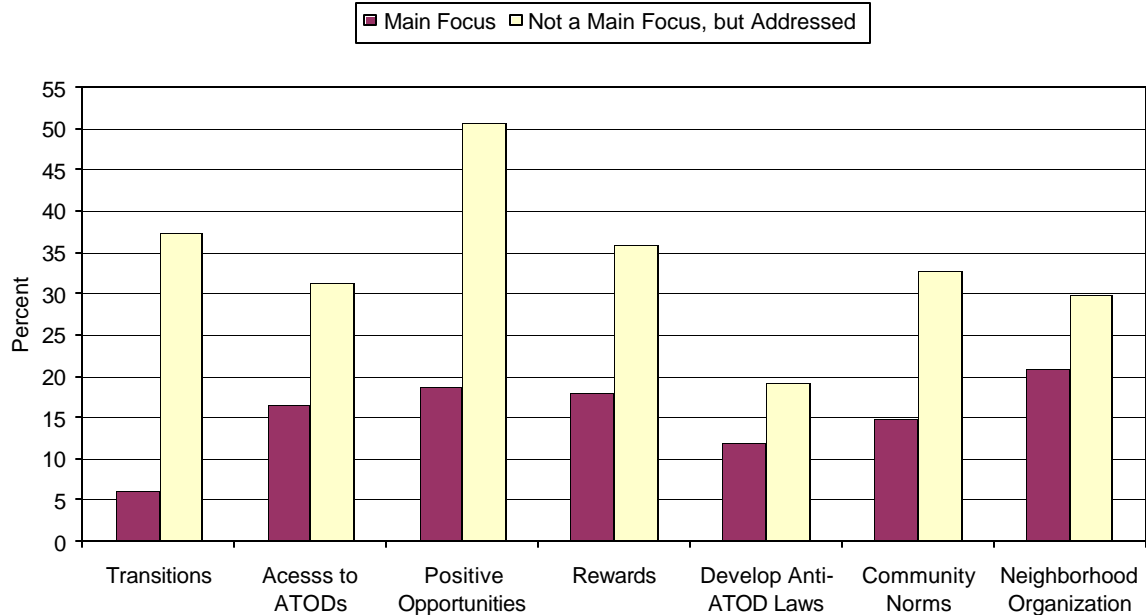
Exhibit 3-51 presents the findings for HPR IV. Thirty percent of respondents in HPR IV reported that *increasing positive community involvement* was a main objective of their program, followed by *improving neighborhood safety, organization, or sense of community* (27.5%) and increasing rewards for positive youth involvement in the community (16%).

Exhibit 3-51.
HPR IV Program Goals and Objectives—Community Domain: Phase II Respondents
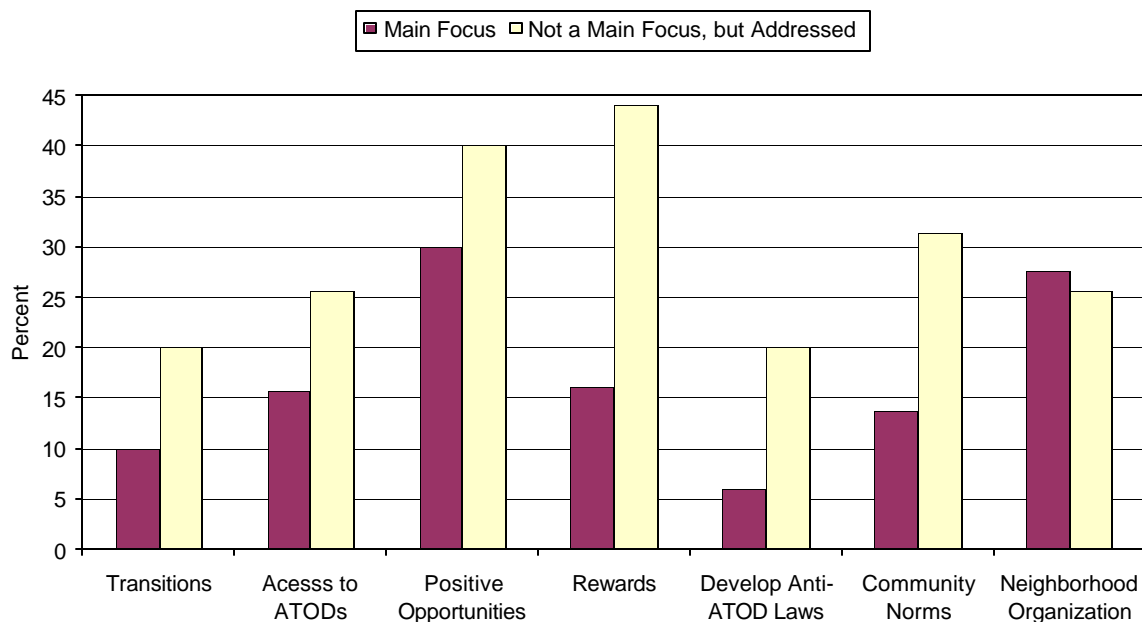
Exhibit 3-52 presents the findings for HPR V. Similar to the Commonwealth findings, one-fourth or less of the respondents in HPR V indicated that objectives in the community domain were a main focus of their programs. The most common objective in HPR V was *improving neighborhood safety, organization, or sense of community* (17.2%), followed by *increasing positive community involvement* (15.5%) and *improving adjustment to transitions to a new home or school* (10.2%).

Exhibit 3-52.
HPR V Program Goals and Objectives—Community Domain: Phase II Respondents
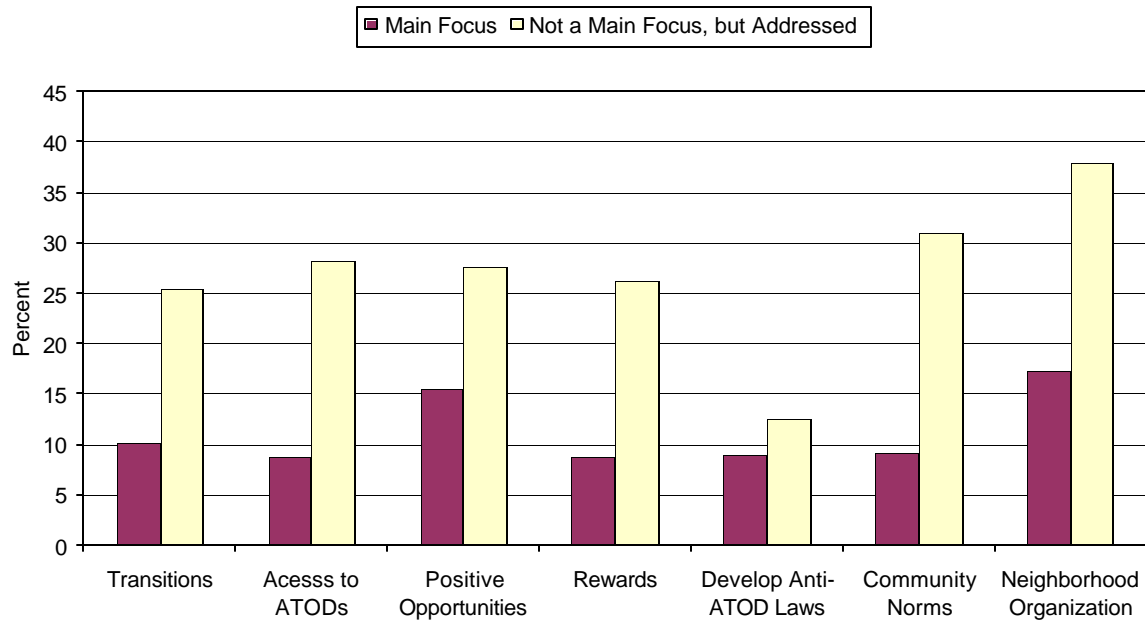
3.2.3 *Program Population*

To obtain information on program populations, respondents were asked to (1) indicate the primary populations served by their program, and (2) provide estimates of population demographics.

3.2.3.1 *Primary Population*

Youth Populations

Exhibit 3-53 presents the findings of the Commonwealth. The most common youth population reported by respondents in the Commonwealth was economically disadvantaged youth (45.3%). The second most common youth population served by programs in the Commonwealth fell into the "other" category (36.1%), followed closely by students at-risk of dropping out (35.8%). The least common youth population reported in the Commonwealth was homeless/runaway youth (11.0%).

**Exhibit 3-53. Commonwealth Primary Population Served by Programs—
Youth Domain: Phase II Respondents**
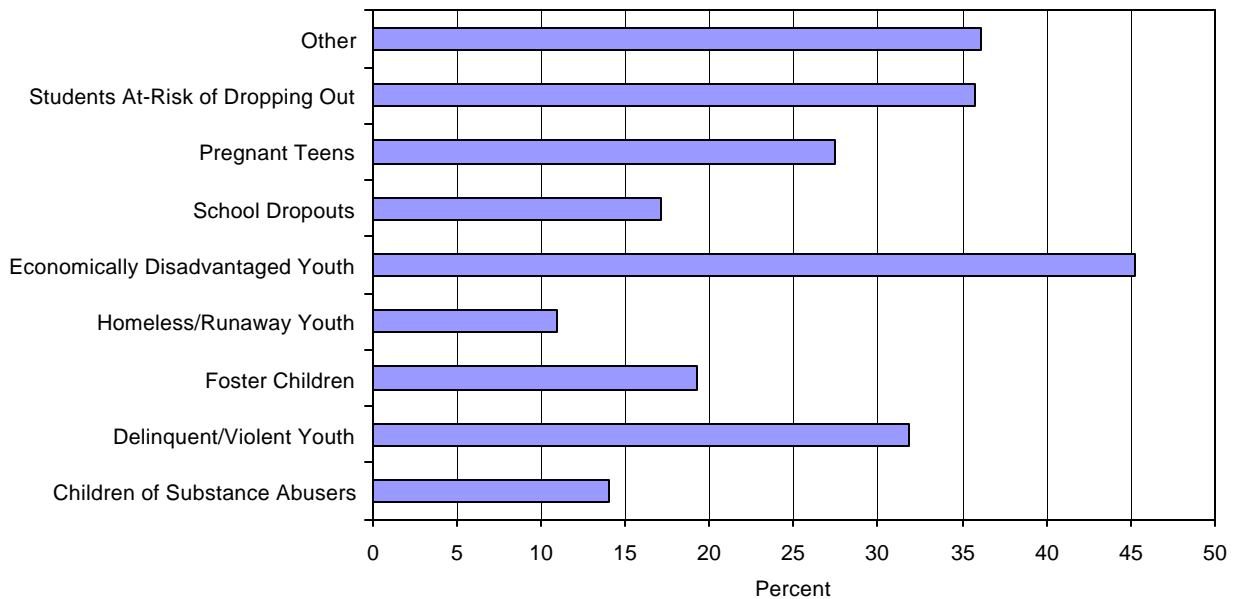
Exhibit 3-54 presents the findings for HPR I. The most common youth population reported by respondents in HPR I was economically disadvantaged youth (45.5%), followed by youth who fell into the "other" category (33.3%). The least common youth population reported by respondents was homeless/runaway youth (6.1%).

Exhibit 3-54. HPR I Primary Population Served by Programs—Youth Domain: Phase II Respondents
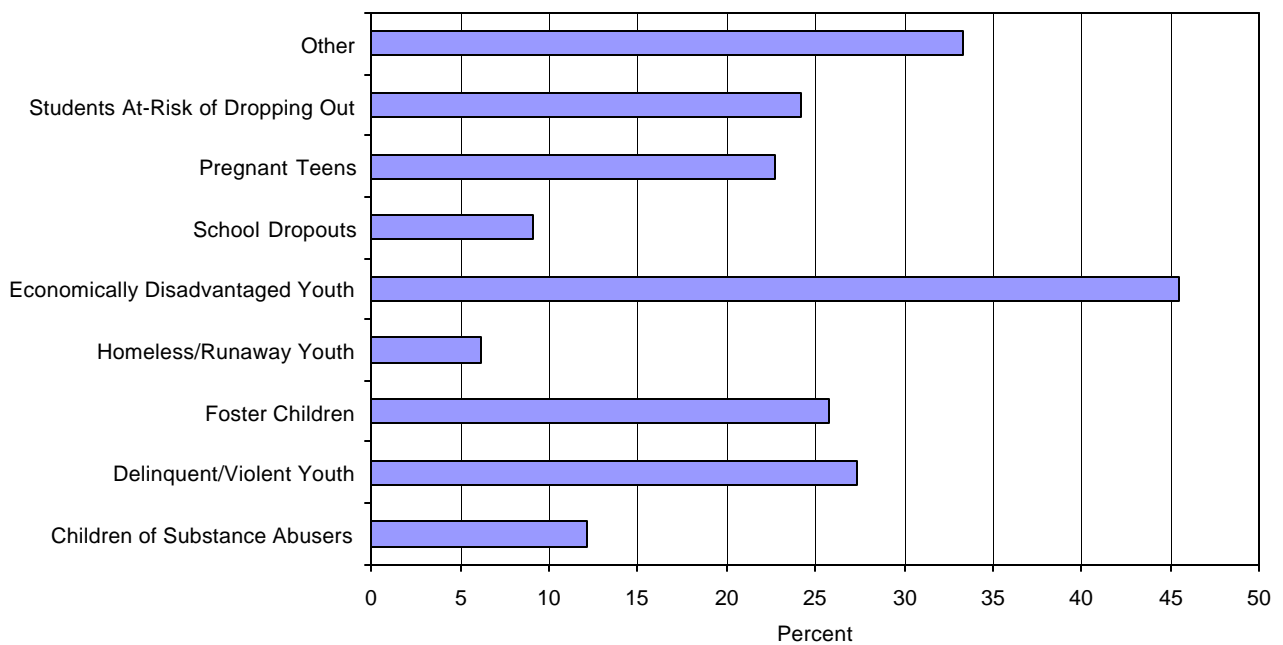
Exhibit 3-55 presents the findings for HPR II. Thirty-seven percent of HPR II respondents reported serving economically disadvantaged youth. The second most common youth population reported was students at-risk for dropping out of school (30.1%). The least common population reported by respondents was homeless/runaway youth (11%) and children of substance abusers (11%).

Exhibit 3-55. HPR II Primary Population Served by Programs—Youth Domain: Phase II Respondents
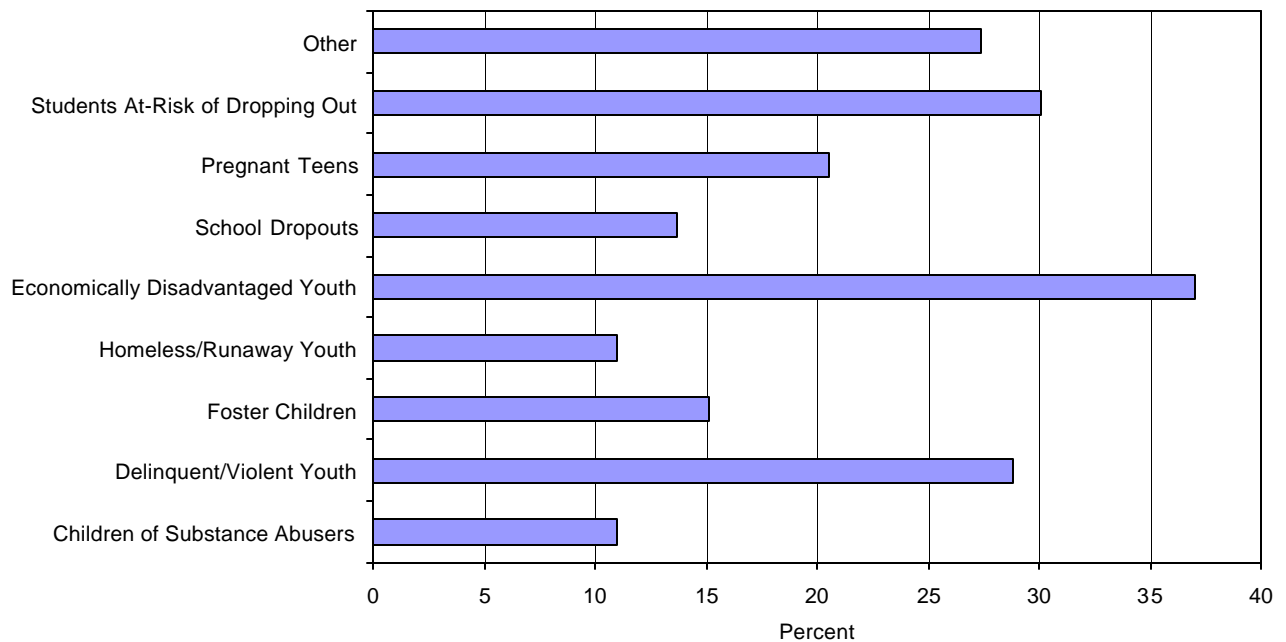
Exhibit 3-56 presents the findings for HPR III. Over half of respondents reported serving economically disadvantaged youth, the most common youth population served in HPR III. Almost half of respondents (42.7%) reported that a primary population of their programs was youth who fell into the "other" category. The least common youth population reported by respondents was homeless/runaway youth (18.7%).

Exhibit 3-56. HPR III Primary Population Served by Programs—Youth Domain:
Phase II Respondents
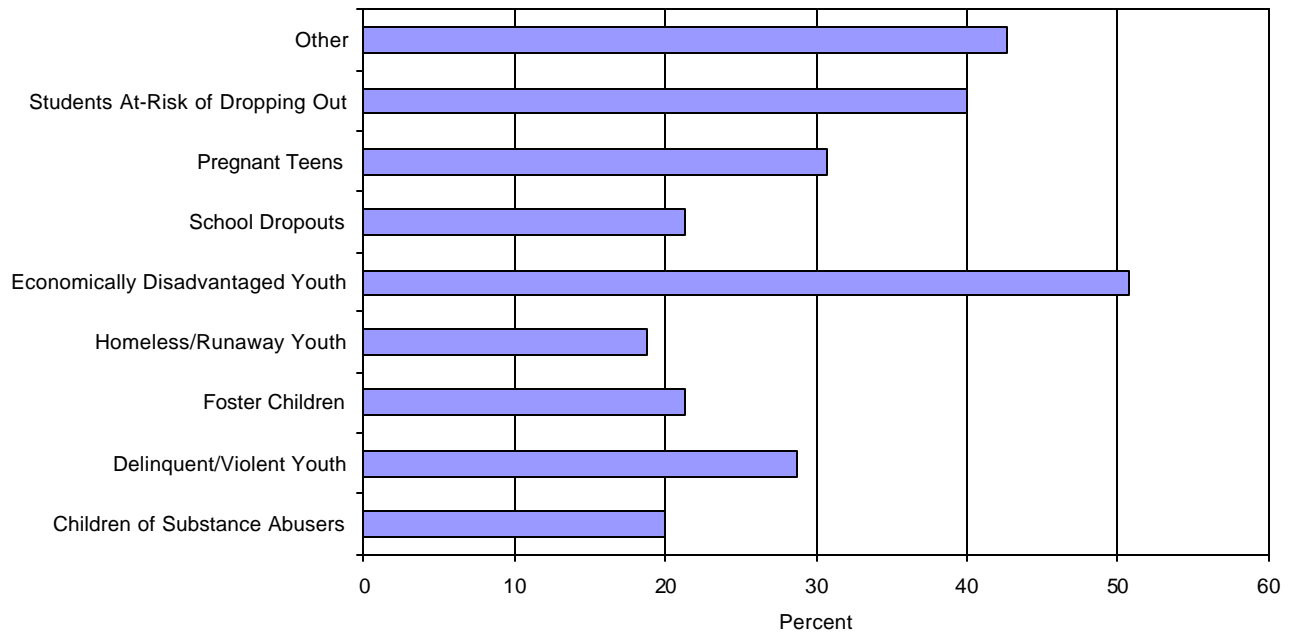
Exhibit 3-57 presents the findings for HPR IV. The two most commonly reported youth populations served by programs in HPR IV were economically disadvantaged youth (51.7%) and students at-risk of dropping out (51.7%). The least common youth population served in HPR IV was homeless/runaway youth (8.3%).

Exhibit 3-57. HPR IV Primary Population Served by Programs—Youth Domain:
Phase II Respondents
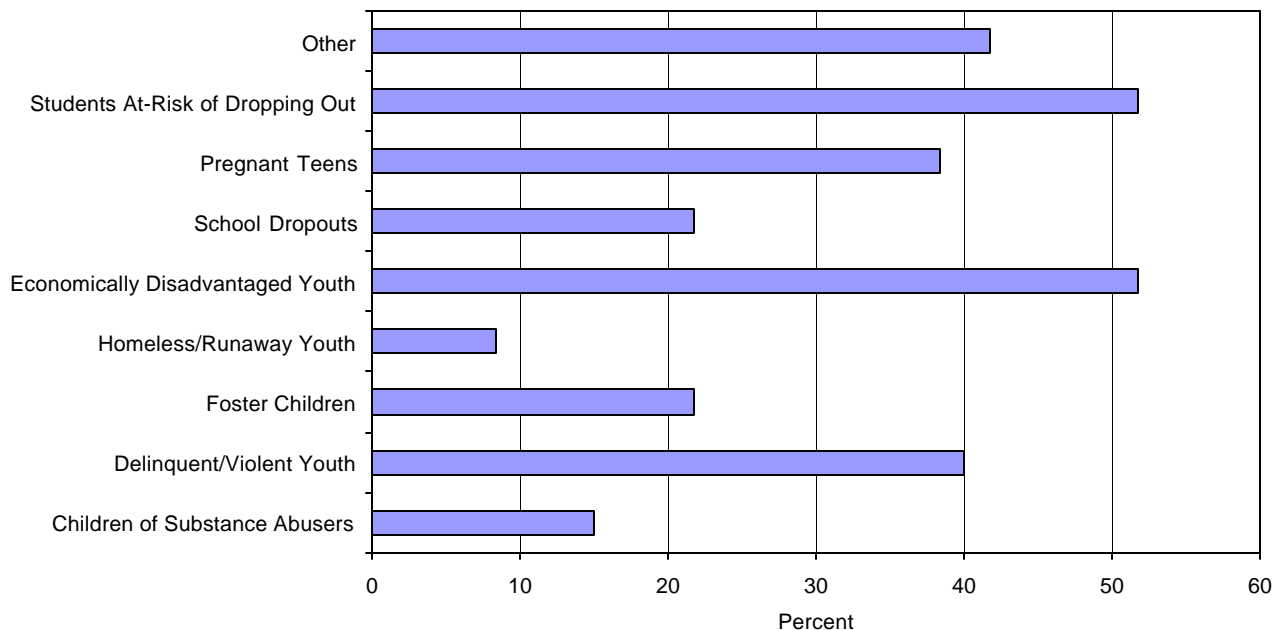
Exhibit 3-58 presents the findings for HPR V. The two most common youth populations reported by respondents in HPR V were economically disadvantaged youth (41.5%) and youth who fell into the "other" category (41.5%). The least common youth population served in HPR V was homeless/runaway youth (9.5%).

Exhibit 3-58. HPR V Primary Population Served by Programs—Youth Domain: Phase II Respondents
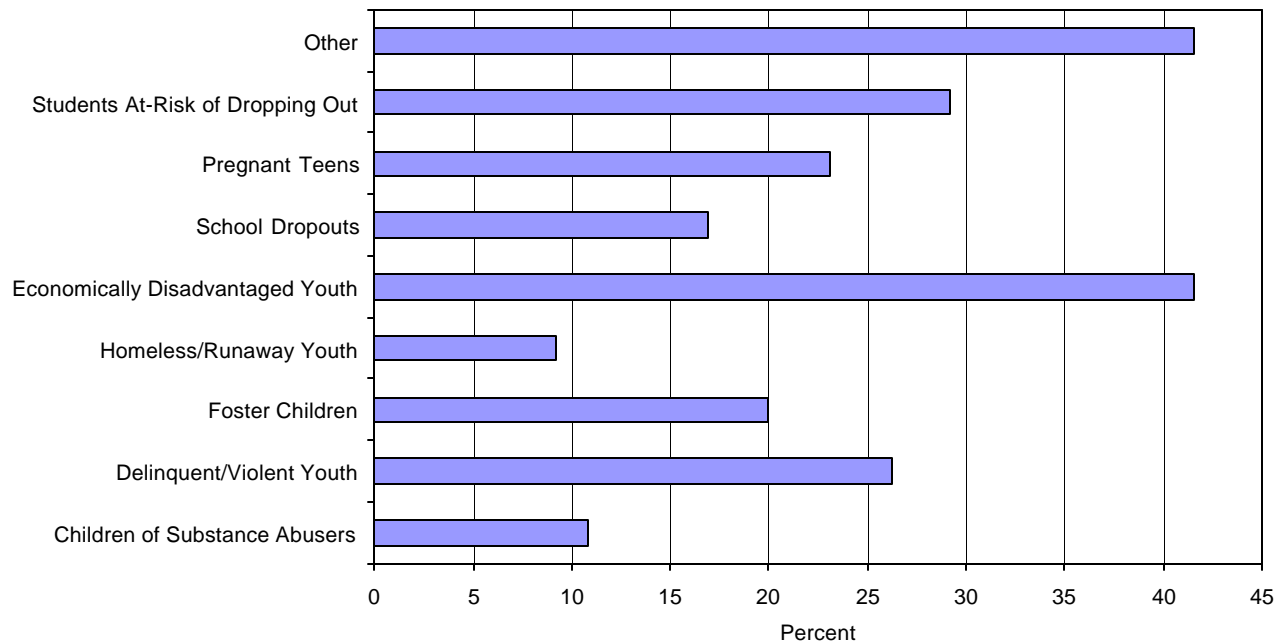
Family Populations

Exhibit 3-59 presents findings of the primary family population served in the Commonwealth. The majority of respondents indicated that the primary populations served by their programs were families. The most common primary population across all domains reported by respondents in the Commonwealth was families and parents (60.9%). Similarly, families and parents were reported to be the most common primary population served by programs in HPRs I (63.6%), II (58.9%), and IV (73.3%). Over half of respondents in HPR III reported families as a primary population (64.0%). HPR V, in comparison to the other HPRs, had the smallest percentage of respondents reporting that families were a primary population (49.2%).

Exhibit 3-59. Primary Population Served by Programs—Family Domain:
Phase II Respondents
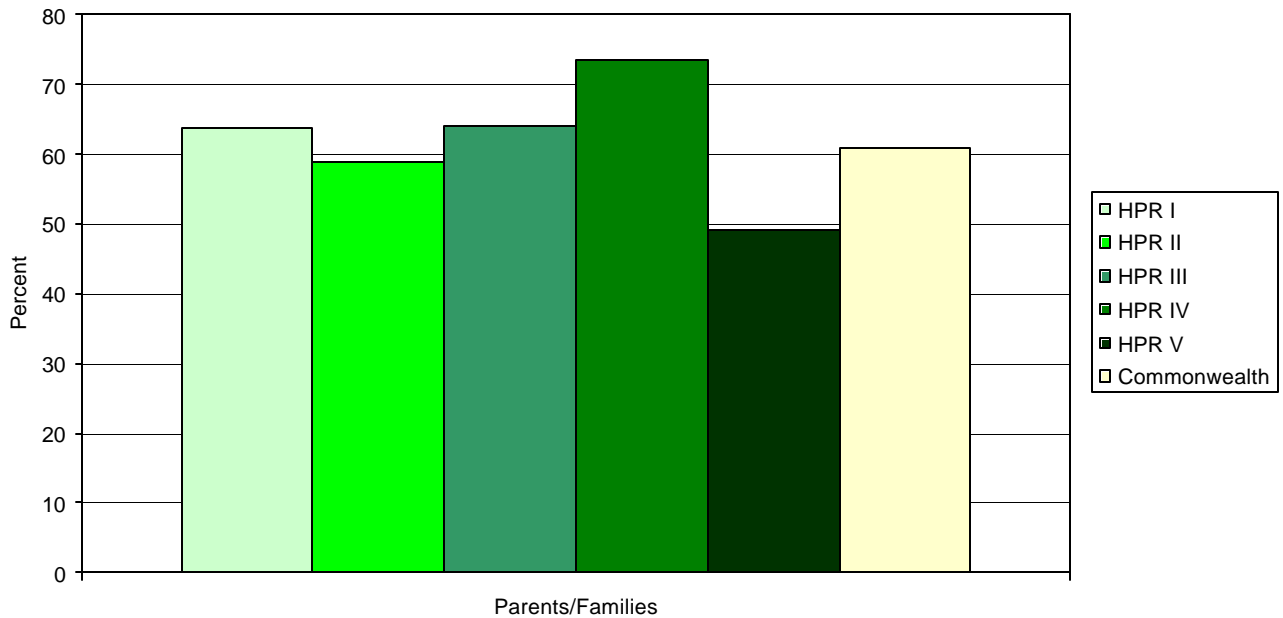
School Populations

Exhibit 3-60 presents findings for the Commonwealth. Over half of the respondents indicated that middle/junior high students (58.7%) and high school students (56.3%) were primary populations served by their programs in the Commonwealth.

Exhibit 3-60. Commonwealth Primary Population Served by Programs—
School Domain: Phase II Respondents
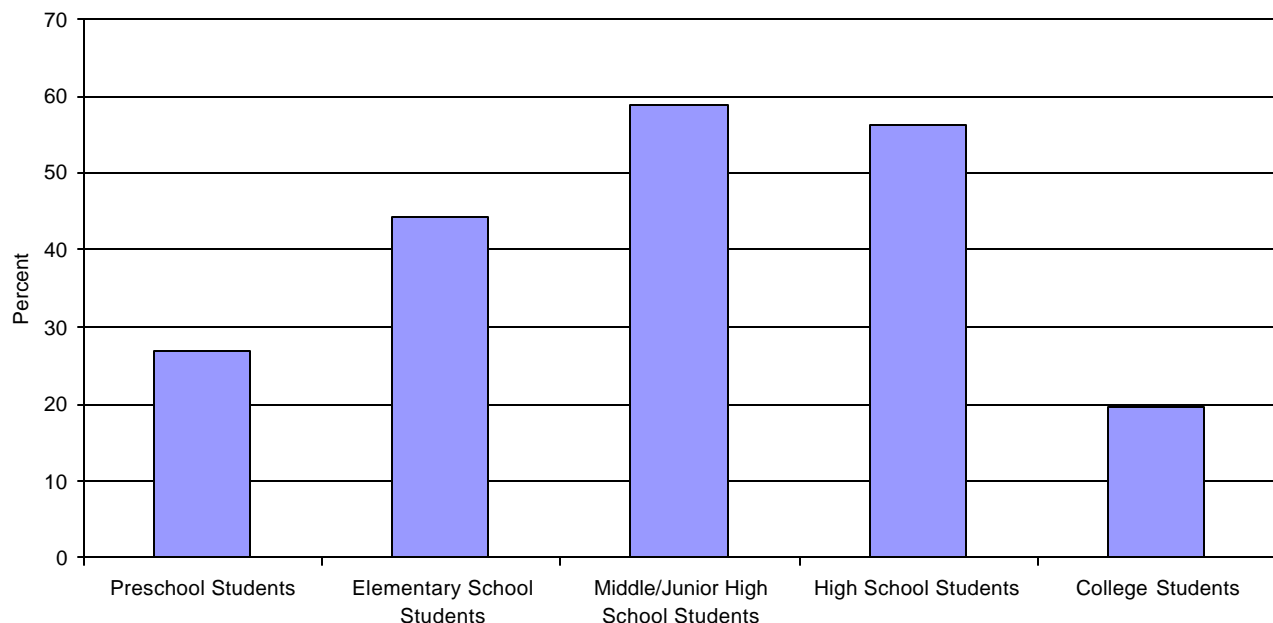
Exhibit 3-61 presents the findings for HPR I. Similar to the Commonwealth, over half of respondents indicated that middle/junior high students (59.1%) and high school students (56.1%) were primary school populations served by their programs.

Exhibit 3-61. HPR I Primary Population Served by Programs—School Domain: Phase II Respondents
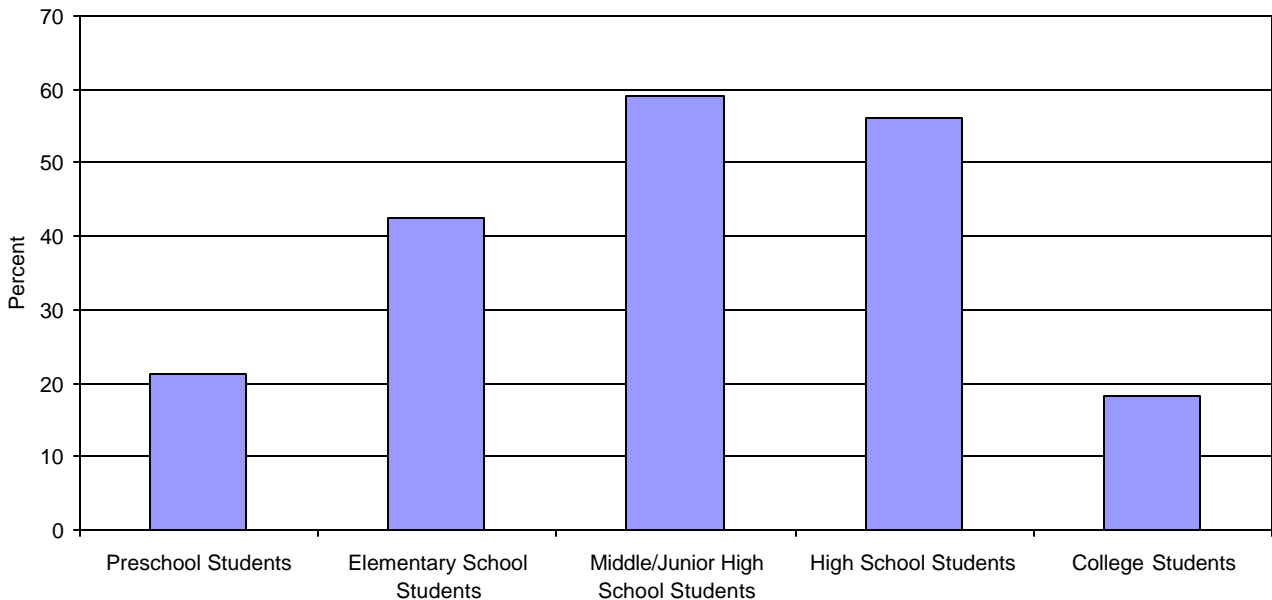
Exhibit 3-62 presents the findings for HPR II. The most common school populations served by programs in HPR II were middle/junior high students (49.3%) and high school students (49.3%).

Exhibit 3-62. HPR II Primary Population Served by Programs—School Domain: Phase II Respondents
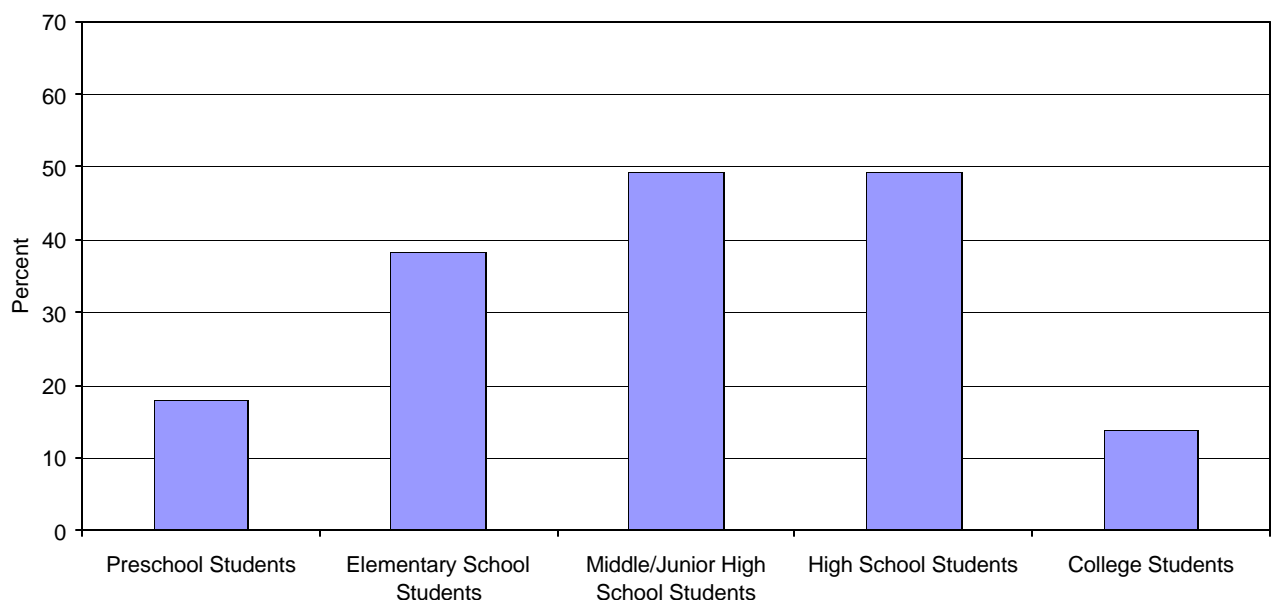
Exhibit 3-63 presents the findings for HPR III. The most common school populations served by programs in HPR III were middle/junior high students (63.9%) and high school students (68.0%).

Exhibit 3-63. HPR III Primary Population Served by Programs—School Domain: Phase II Respondents
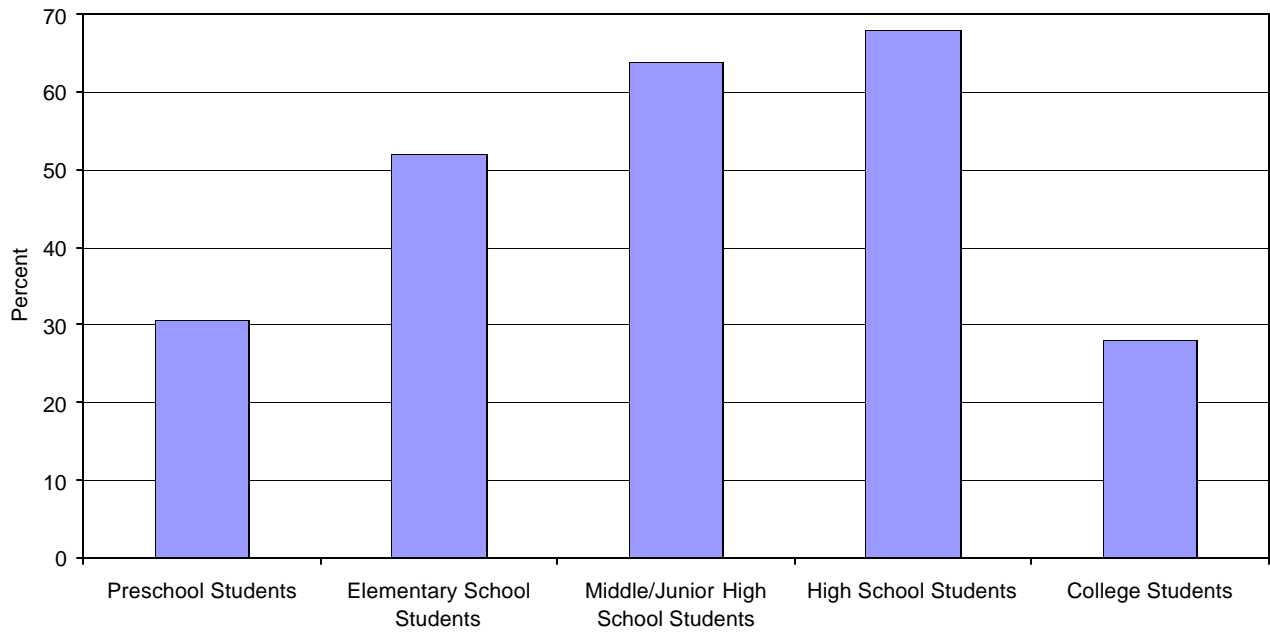
Exhibit 3-64 presents the findings for HPR IV. The most common school populations served by programs in HPR IV were middle/junior high students (61.7%) and high school students (56.7%).

Exhibit 3-64. HPR IV Primary Population Served by Programs—School Domain: Phase II Respondents
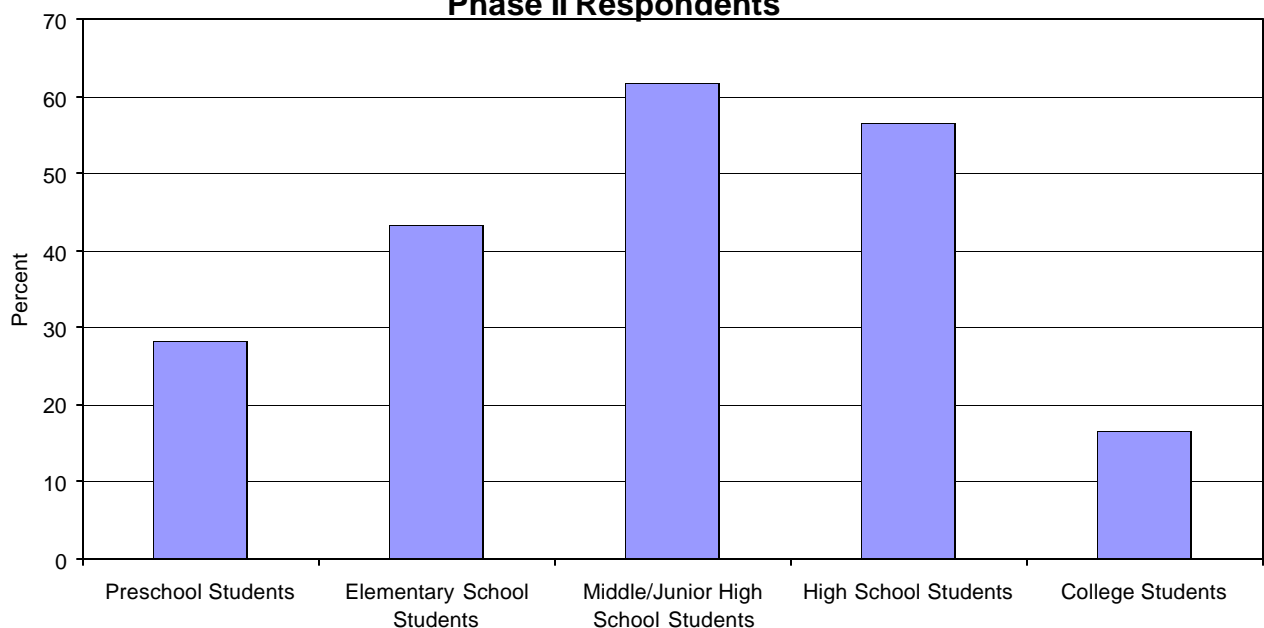
Exhibit 3-65 presents the findings for HPR V. The most common school populations served by programs in HPR II were middle/junior high students (58.5%) and high school students (55.4%).

Exhibit 3-65. HPR V Primary Population Served by Programs—School Domain: Phase II Respondents
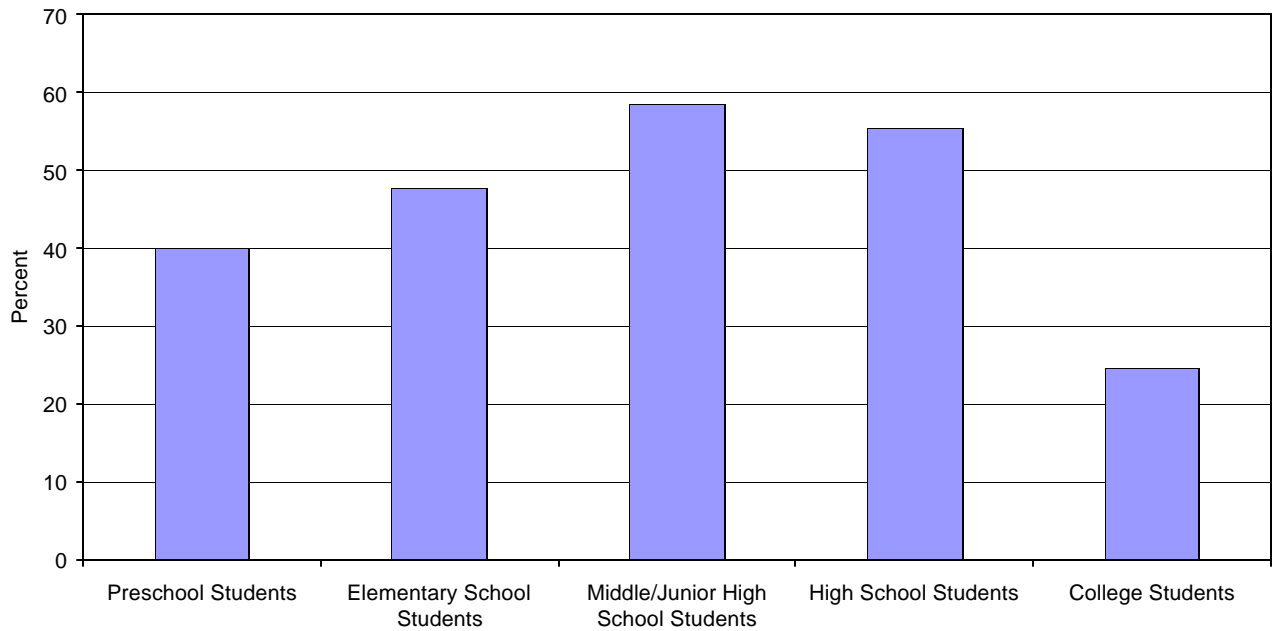
Community Populations

Exhibit 3-66 presents the findings of the Commonwealth. Community populations that respondents in the Commonwealth were most likely to report they served were the economically disadvantaged (45.6%). The second most commonly reported community population served by programs was women of childbearing age (28.4%). Less than 10 percent of respondents indicated that their programs served the following populations in the community:

- Law enforcement/military (9.2%);

- Gays and lesbians (6.1%);

- Government/elected officials (5.5%); and

- Migrant workers (4.3%).

**Exhibit 3-66. Commonwealth Primary Population Served by Programs—
Community Domain: Phase II Respondents**
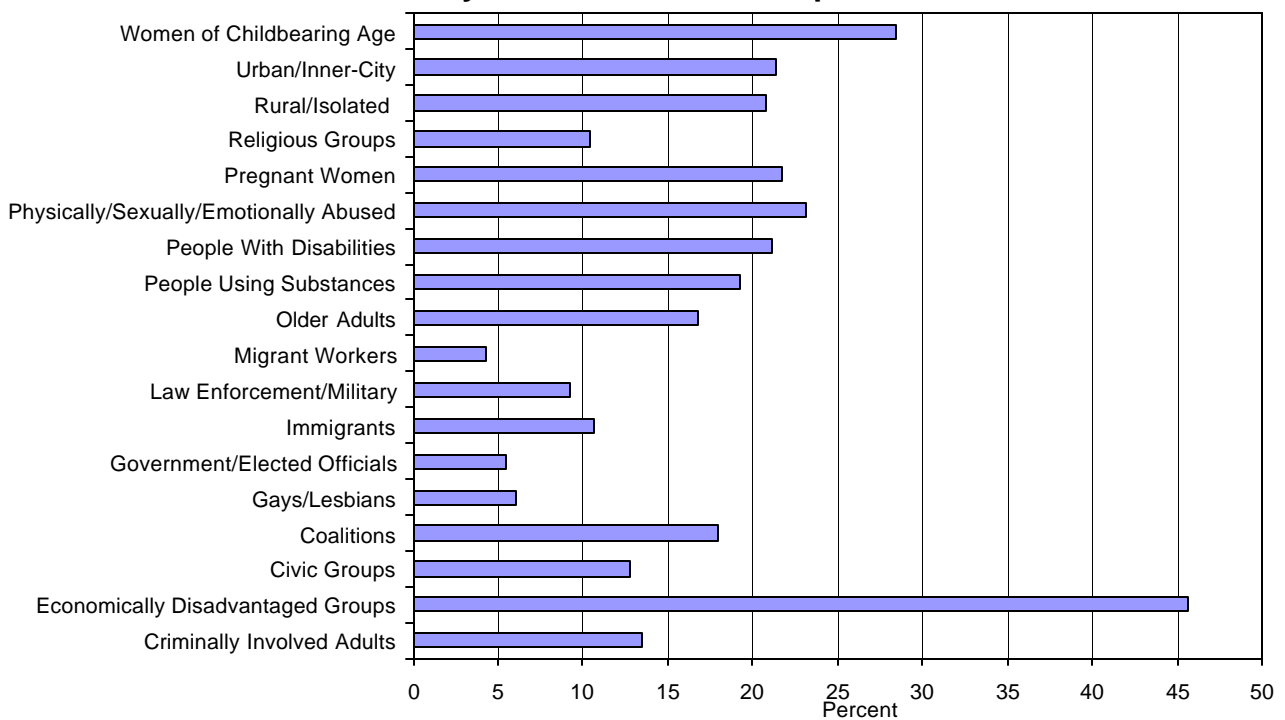
Exhibit 3-67 presents findings for HPR I. The most common population served by programs in HPR I was the economically disadvantaged (33.3%), followed by women of childbearing age (25.8%). In HPR I, less than 10 percent of respondents indicated that their programs served the following populations in their community:

- Civic groups (9.1%);
- Urban/inner-city youth (7.6%);
- Government/elected officials (6.1%);
- Immigrants and refugees (4.5%);
- Law enforcement/military (4.5%);
- Migrant workers (3%); and
- Gays and lesbians (1.5%).

Exhibit 3-67. HPR I Primary Population Served by Programs—Community Domain: Phase II Respondents
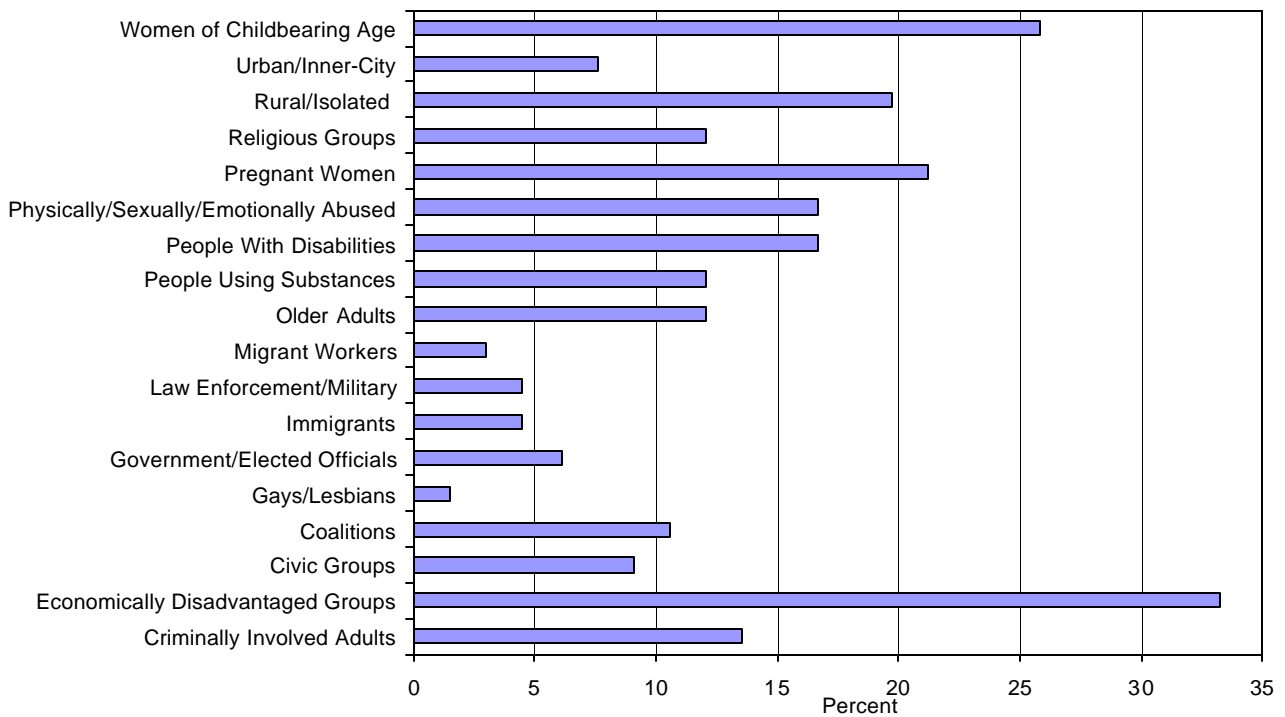
Exhibit 3-68 presents the findings for HPR II. The most commonly reported primary community population group served in HPR II was the economically disadvantaged (over 53.4%), followed by immigrants (32.9%). Less than 10 percent of respondents reported serving the following populations:

- Gays and lesbians (9.6%);
- Religious groups (8.2%);
- Coalitions (8.2%);
- Civic groups (5.5%);
- Rural/isolated populations (5.5%).
- Migrant workers (5.5%); and
- Government/elected officials (1.4%).

Exhibit 3-68. HPR II Primary Population Served by Programs—Community Domain: Phase II Respondents
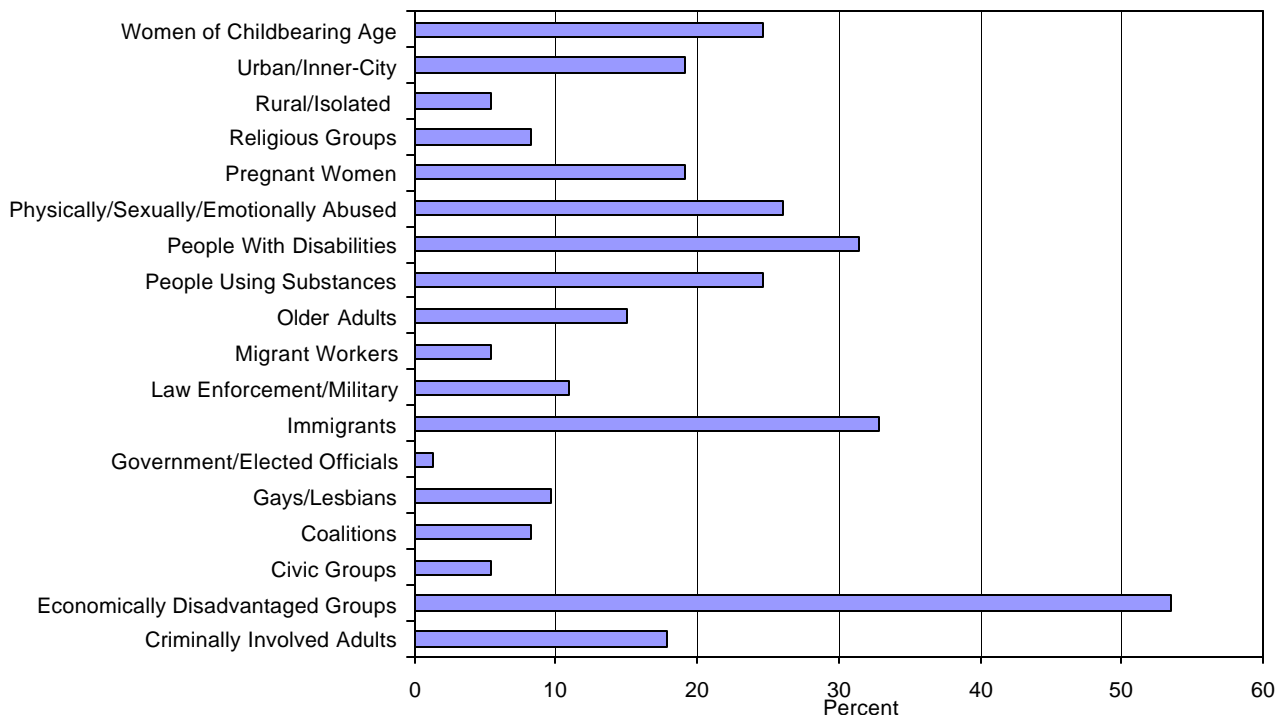
Exhibit 3-69 presents the findings for HPR III. The most commonly reported community populations served by programs in HPR III were economically disadvantaged groups (42.7%) and women of childbearing age (32%). Less than 10 percent of respondents reported the following populations as primary to their programs:

- Law enforcement (9.3%);

- Gays and lesbians (8%);

- Immigrants and refugees (8%); and

- Migrant workers (2.7%).

Exhibit 3-69. HPR III Primary Population Served by Programs—Community Domain: Phase II Respondents
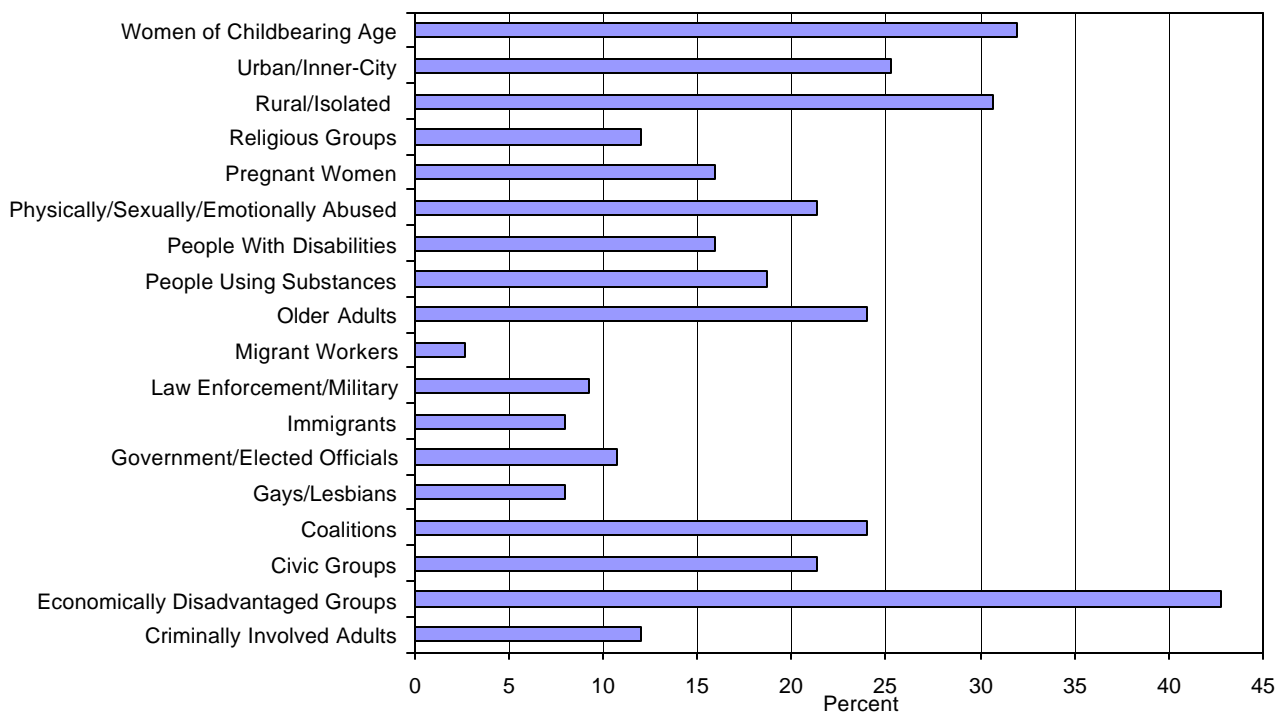
Exhibit 3-70 presents the findings for HPR IV. The most commonly reported primary community population served in HPR IV was the economically disadvantaged (53.3%). The second most common primary population served by programs in HPR IV was women of childbearing age (31.7%). Less than 10 percent of respondents reported the following as primary populations of their programs:

- Criminally involved adults (8.3%);

- Government/elected officials (8.3%);

- Law enforcement (6.7%);

- Immigrants and refugees (5.0%);

- Migrant workers (3.3%); and

- Gays and lesbians (3.3%).

Exhibit 3-70. HPR IV Primary Population Served by Programs—Community Domain: Phase II Respondents
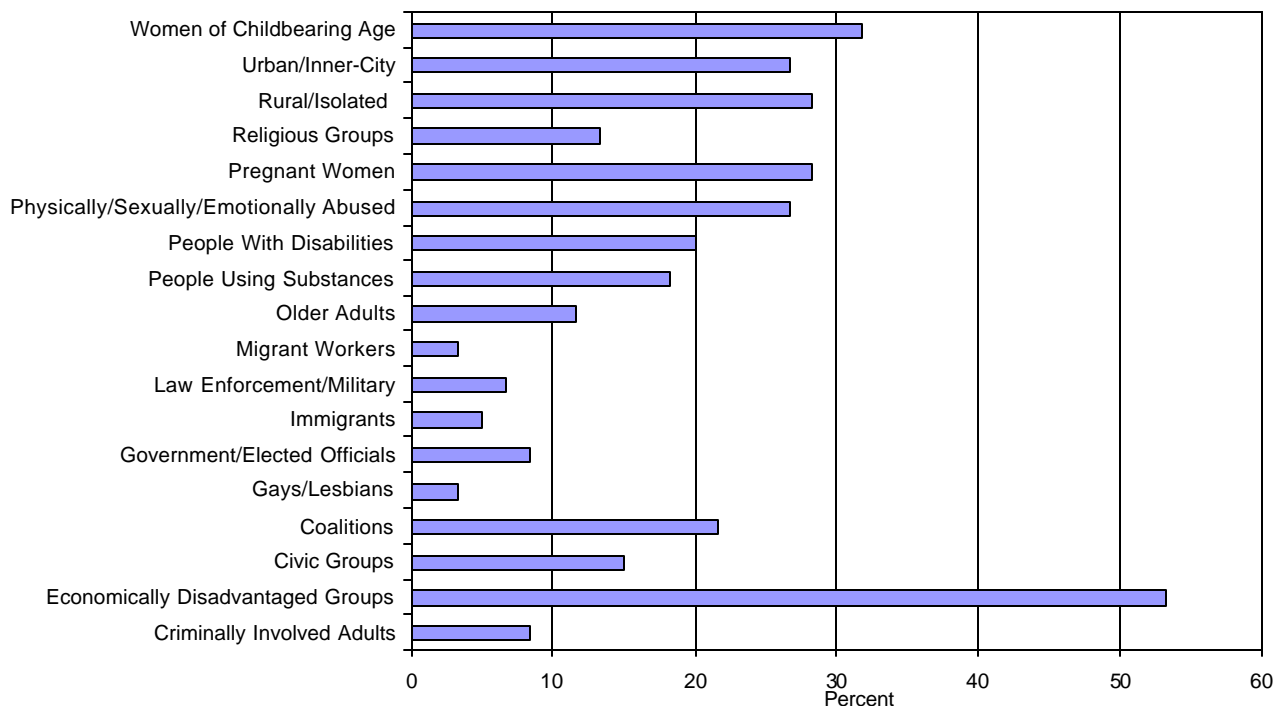
Exhibit 3-71 presents the findings for HPR V. The most common community population served in HPR V was the economically disadvantaged (41.5%), followed by women of childbearing years (27.7%) and abused populations (26.2%). Less than 10 percent of respondents reported the following as primary populations of their programs:

- Religious groups (7.7%);

- Gays and lesbians (6.2%);

- Migrant workers (6.2%); and

- Immigrants (1.5%).

Exhibit 3-71. HPR V Primary Population Served by Programs—Community Domain: Phase II Respondents
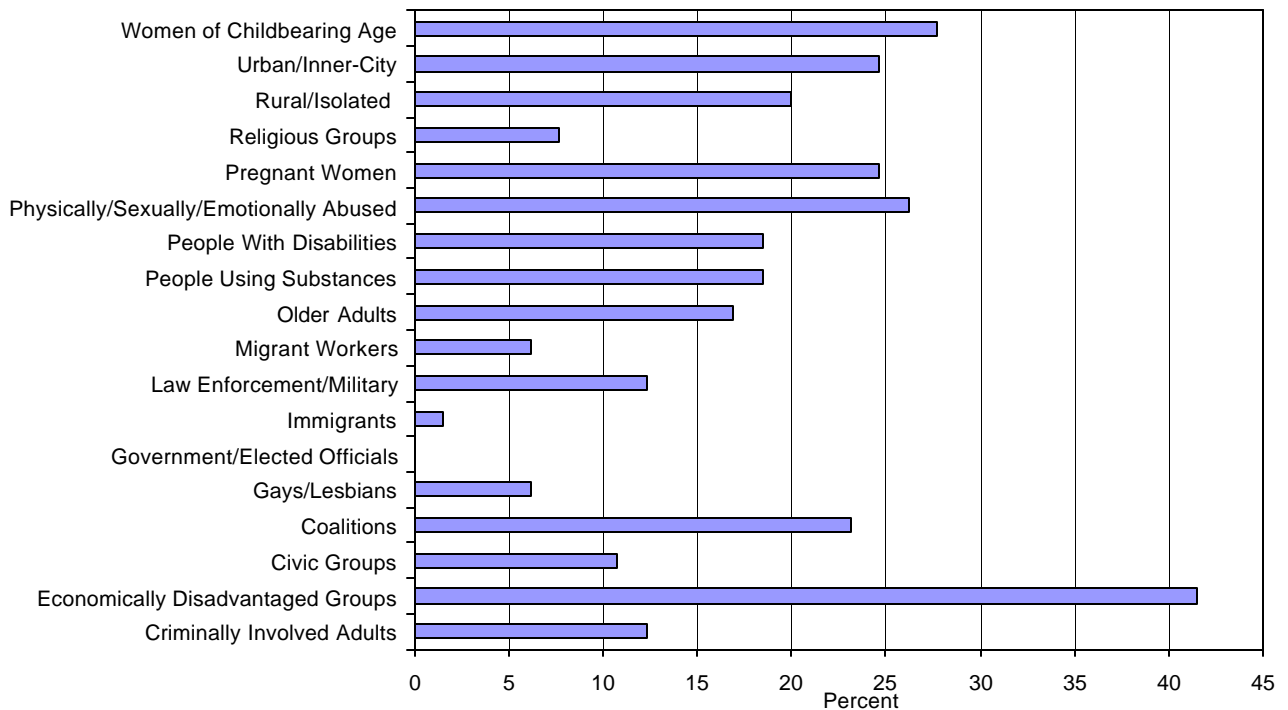
Business Populations

Exhibit 3-72 presents the findings for the Commonwealth. Teachers, administrators, or school counselors (32.4%) were the most common primary populations served within the business community, as reported by respondents in the Commonwealth. Less than 10 percent of respondents indicated that managed care organizations (4.9%) were a primary population served by their programs.

Exhibit 3-72. Commonwealth Primary Population Served by Programs—Business/Work Populations: Phase II Respondents
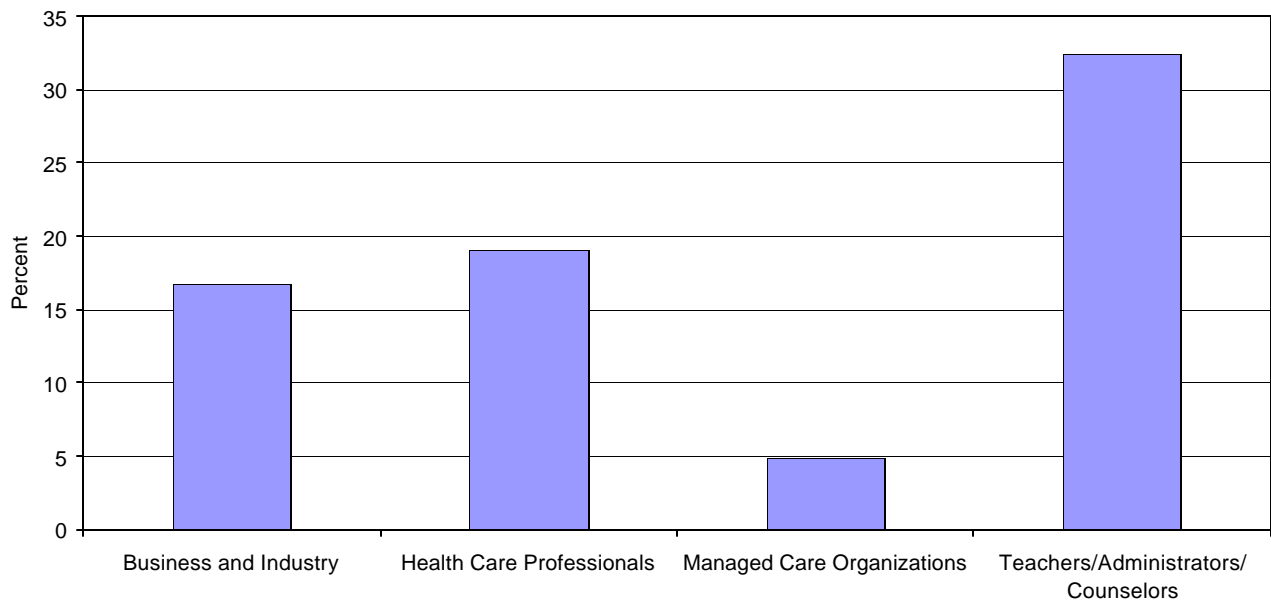
Exhibit 3-73 presents the findings for HPR I. Similarly, within the Business Community, school personnel were the most common population reported by respondents in HPR I (30.3%). In addition, the least common population served by program in HPR I was managed care organizations (1.5%).

Exhibit 3-73. HPR I Primary Population Served by Programs—Business/Work Populations: Phase II Respondents
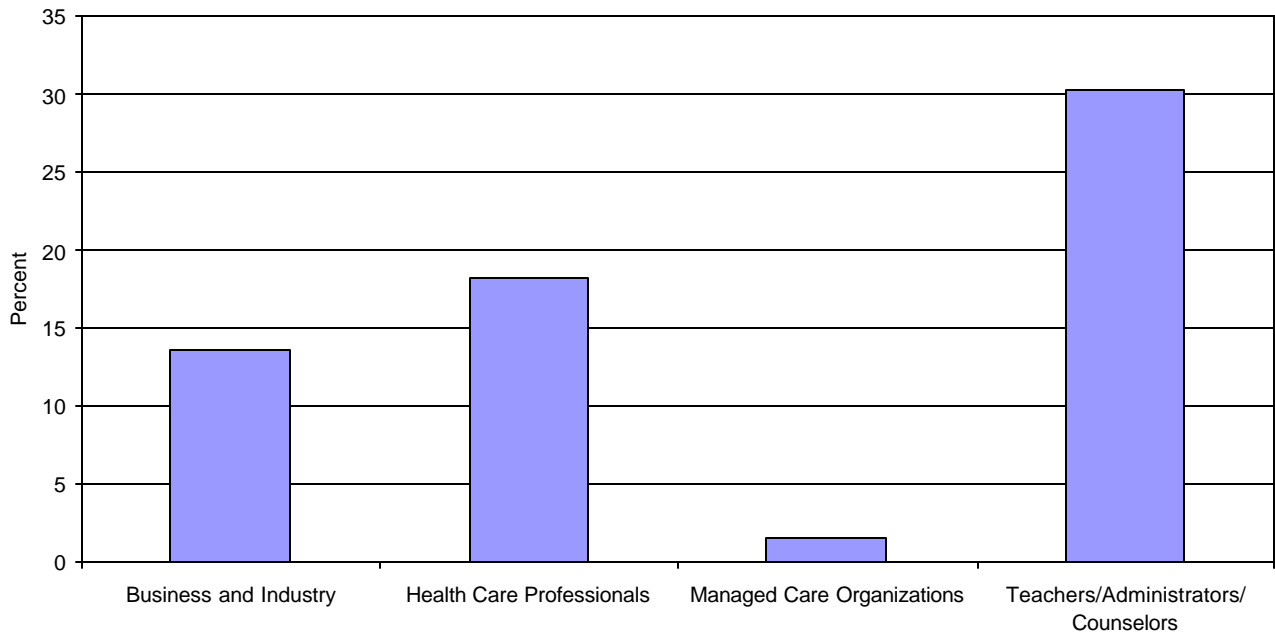
Exhibit 3-74 presents the findings for HPR II. The most common population served in HPR II was school personnel (28.8%), whereas the least common population reported by respondents in HPR II was managed care organizations (2.7%).

Exhibit 3-74. HPR II Primary Population Served by Programs—Business/Work Populations: Phase II Respondents
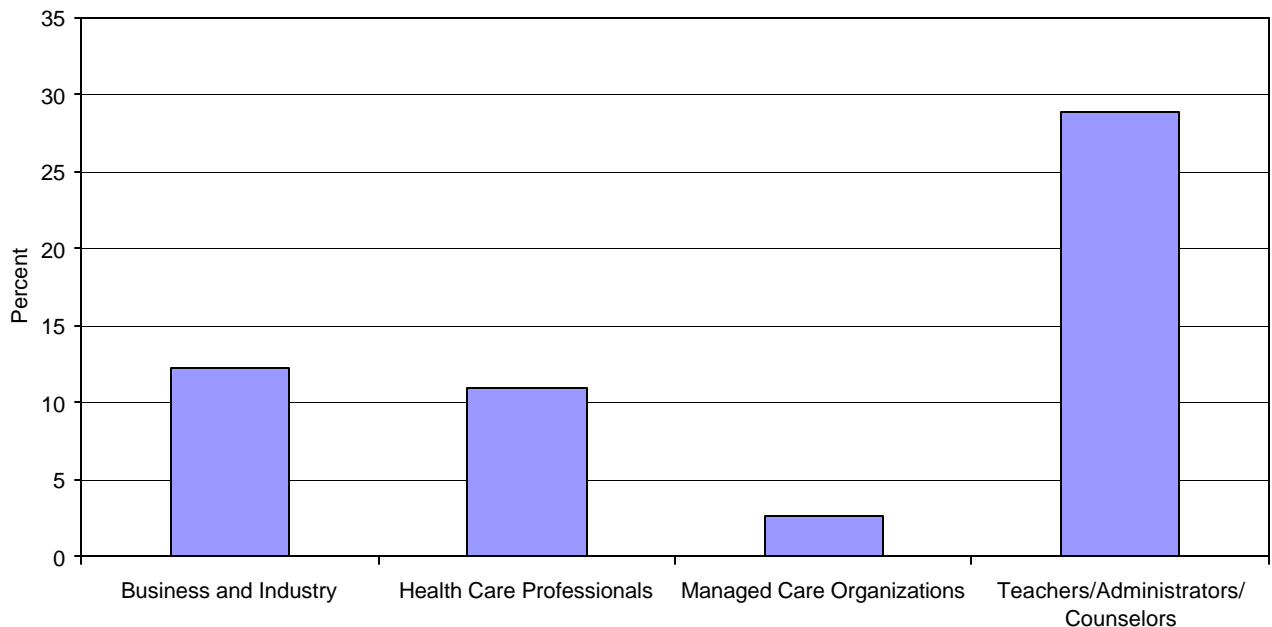
Exhibit 3-75 presents the findings for HPR III. As with the other HPRs, school personnel was the most common population reported by respondents in HPR IIII (33.3%), whereas the least common population reported by respondents in HPR I was managed care organizations (4.0%).

**Exhibit 3-75. HPR III Primary Population Served by Programs—
Business/Work Populations: Phase II Respondents**
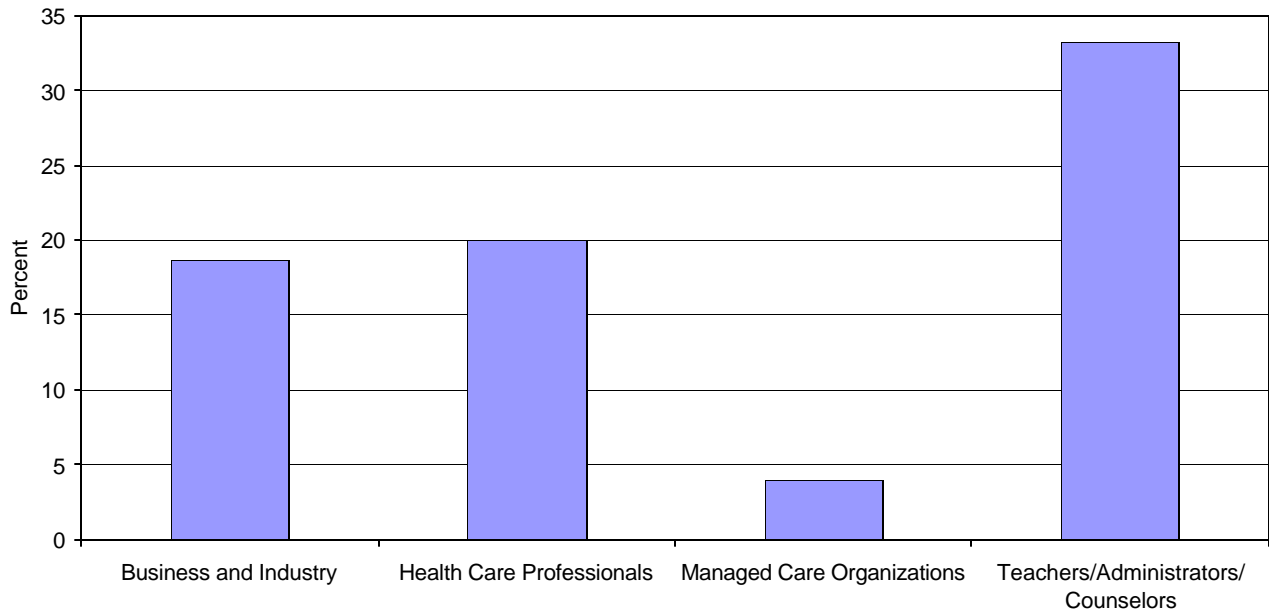
Exhibit 3-76 presents the findings for HPR IV. In HPR IV, school personnel was the most common population reported by respondents (33.3%), whereas the least common population reported by respondents in HPR II was managed care organizations (3.3%).

**Exhibit 3-76. HPR IV Primary Population Served by Programs—
Business/Work Populations: Phase II Respondents**
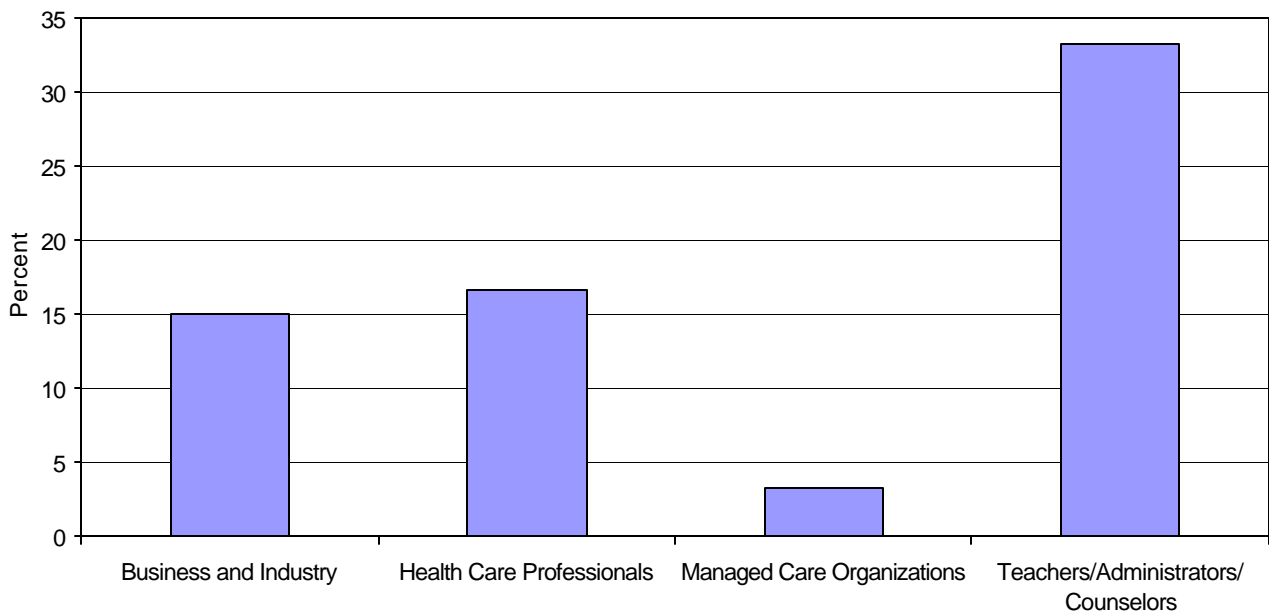
Exhibit 3-77 presents the findings for HPR V. The most commonly reported population served in HPR V was school personnel (33.8%), whereas the least common population reported by respondents in HPR II was managed care organizations (12.3%).

Exhibit 3-77. HPR V Primary Population Served by Programs—Business/Work Populations: Phase II Respondents
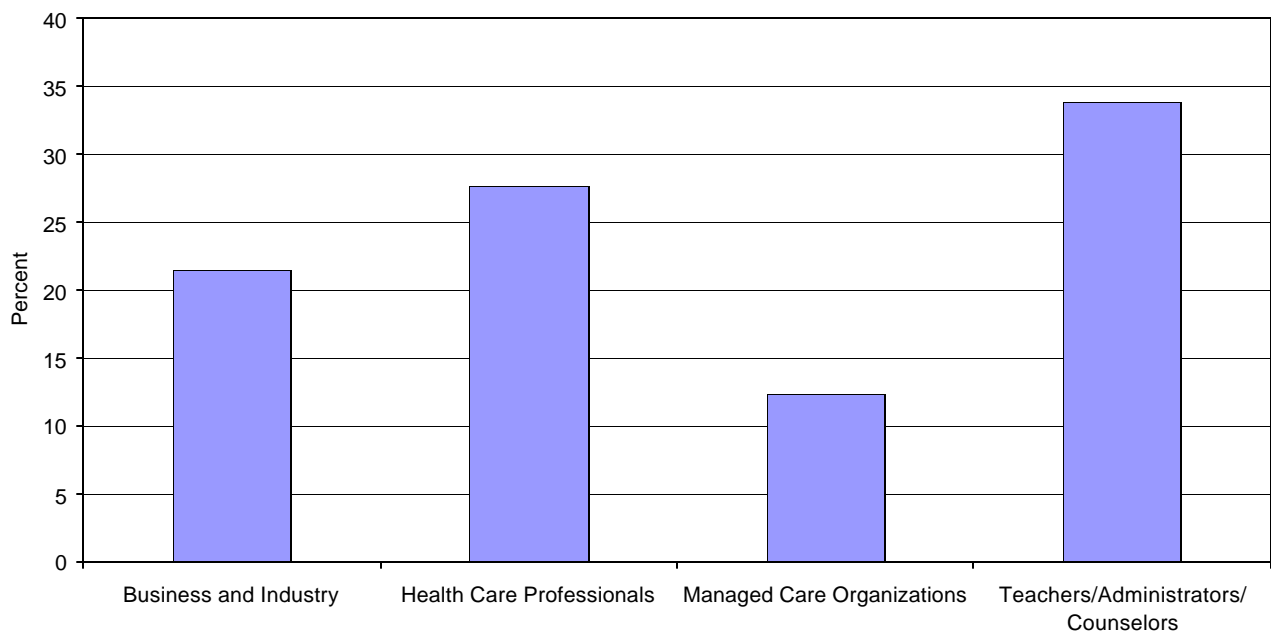
3.2.3.2   *Demographics*

To collect demographic information on program participants, respondents were asked to provide information on the age, race/ethnicity, and gender of program participants. Respondents were asked to estimate the percentage of participants in particular age, gender, and racial/ethnic categories. The findings presented in this section are the average percentage reported by respondents.

Age

Exhibit 3-78 presents information on program participants' age. To collect information on program participants' age, respondents were asked to report the percentage of participants in the following age groups: 0–4, 5–11, 12–14, 15–17, 18–20, 21–24, 25–44, 45–64, and 65 and older. The findings described below are the average percentages of participants that fell into each of the age groups as reported by respondents.

Exhibit 3-78. Average Percentage of Participants by Age

Age Group	Commonwealth		HPR I		HPR II		HPR III		HPR IV		HPR V	
	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range
0–4	11.21	0–100	11.28	0–100	9.78	0–100	11.31	0–95	13.91	0–100	12.34	0–100
5–11	18.55	0–100	18.95	0–100	14.33	0–90	21.82	0–99	21.48	0–80	16.42	0–99
12–14	17.68	0–94	18.67	0–90	14.51	0–60	22.90	0–94	12.58	0–80	20.64	0–75
15–17	19.29	0–100	20.42	0–100	17.28	0–97	19.10	0–98	15.44	0–85	25.77	0–80
18–20	7.03	0–100	7.37	0–80	8.37	0–100	5.05	0–30	8.62	0–70	4.89	0–35
21–24	7.11	0–80	8.23	0–80	10.0	0–61	4.38	0–30	7.54	0–46	4.13	0–40
25–44	10.76	0–85	10.80	0–85	16.30	0–80	6.7	0–50	10.51	0–72	7.92	0–70
45–64	4.69	0–77	4.08	0–77	4.93	0–32.5	3.2	0–30	5.49	0–54	5.7	0–50
65+	1.88	0–77	1.8	0–77	1.08	0–13	2.24	0–40	1.67	0–30	2.4	0–40

On average, respondents reported that the largest percentage of participants fell into the 5–11, 12–14, and 15–17 age groups. More specifically, respondents indicated that, on average, approximately 10 percent of participants fell into the 0–4 and 25–44 age groups. A significantly smaller percentage of participants fell into the 18–24 and 45 or older age groups.

The age of program participants varied across HPRs. The findings for HPR I were similar to the Commonwealth. On average, the largest percentage of participants fell into the 5–11, 12–14, and 15–17 age groups. A little more than 10 percent of participants were reported by respondents to fall into the 0–4 and 25–44 age groups, and a significantly smaller percentage of participants fell into the 18–24 and 45 or older age groups. In HPR II, the largest percentage of participants were in the 15–17 and 25–44 age groups. Less than 10 percent of participants fell into the 0–4, 18–24, and 45 and older age groups. In HPR III, the pattern of results is similar to the results obtained in the Commonwealth, with the largest percentage of participants falling into the 5–11, 12–14, and 15–17 age groups. In HPR IV, a larger percentage of participants, as compared to the other HPRs, fell into the 15–17 age group. In HPR V, the largest percentage of participants fell into the 12–14 age group.

Gender

Respondents were asked to indicate the percentage of program participants that were male and female. The following findings discuss the average percentage of participants that fall into each gender category.

Exhibit 3-79 presents the findings on the gender of program participants. . Respondents reported a significantly higher percentage of female participants compared to male participants (56.91% versus 42.76%, respectively). Similar results were found across all five HPRs, with a significantly larger percentage of female participants. This finding is particularly striking in HPRs IV and V, in which approximately 60 percent of participants are reported to be female.

Exhibit 3-79. Average Percentage of Participants by Gender

| | Male | | Female | |
	Average	Range	Average	Range
Commonwealth	45.28	0–99	57.38	1–100
HPR I	42.43	0–90	56.68	10–100
HPR II	46.56	1–99	53.44	1–99
HPR III	44.96	5–98	55.04	2–95
HPR IV	40.12	0–87	59.86	13–100
HPR V	38.60	1–90	60.51	10–99

Race/Ethnicity

To collect information on race/ethnicity of program participants, respondents were asked to indicate the percentage of participants that fall into the following categories: Caucasian, African-American, Asian, Hispanic, Native American, and Multiracial.

Exhibit 3-80 presents the findings on program participants' race/ethnicity. The largest average percentage of participants reported by respondents fell into the Caucasian racial category in the Commonwealth. In addition, over one-third of participants fell into the African-American category. A relatively small number of participants fell into the other four racial/ethnic categories.

The racial makeup of participants varied across HPRs. Similar to the Commonwealth findings, Caucasians and African-Americans make up the largest percentages of participants in HPRs I, III, IV, and V; relatively few participants fell into the other racial/ethnic categories. In contrast, in HPR II, almost one-third of the participants were Hispanic (27.63%) and a relatively similar percentage of participants were Caucasian and African-American.

In HPRs I and III, the largest percentage of participants are Caucasian, which is similar to the Commonwealth findings. In HPR III, the overwhelming majority of participants were reported to be Caucasian (71.27%), whereas in HPRs IV and V, more than 50 percent of the participants were reported to be African-American.

Exhibit 3-80. Average Percentage of Participants by Race/Ethnicity

| | Caucasian | | African American | | Asian | | Hispanic | | Multiracial | | Native American | |
	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range
Commonwealth	47.91	0–99	38.06	1–99	1.80	0–75	7.90	0–80	3.10	0–50	.33	0–20
HPR I	57.18	0–97	30.47	0–90	.98	0–14	4.07	0–35	3.65	0–50	.73	0–20
HPR II	34.85	0–88	28.29	4–90	4.39	0–75	27.63	0–80	4.40	0–40	.18	0–3
HPR III	71.27	3–99	23.38	0–97	.91	0–10	1.61	0–10	3.29	0–20	.33	0–5
HPR IV	41.01	0–99	52.75	10–99	1.75	0–20	2.70	0–15	2.15	0–10	.36	0–5
HPR V	30.86	0–95	61.45	5–99	.74	0–10	1.87	0–10	2.02	0–20	.13	0–3

3.2.4   *Number of Participants*

Exhibit 3-81 presents the findings on the average number of program participants. The average number of program participants within the last 12 months in the Commonwealth was 1,172.79, with a range of 0 to 52,000. In HPR I, the average number of participants served in the last 12 months was 465.90, with a range of 20 to 5,000. In HPR II, the average number of participants served in the last 12 months was 2,370.87, with a range of 0 to 52,000. In HPR III, the average number of participants served was 751.34, with a range of 4 to 12,000. In HPR IV, the average number of participants served was 1,102.31, with a range of 2 to 34,000. In HPR V, the average number of participants served was 846.06, with a range of 2 to 11,184.

Exhibit 3-81. Average Number of Program Participants

	Program Partcipants	
	Average	**Range**
Commonwealth	1,172.79	0–52,000
HPR I	465.90	20–5,000
HPR II	2,370.87	0–52,000
HPR III	751.34	4–12,000
HPR IV	1,102.31	2–34,000
HPR V	846.06	2–11,184

3.2.5   *Program Components*

Information collected on program components included data on the types of services provided by programs and data on program intensity.

3.2.5.1   *Service Provision*

To collect information on the types of services provided by programs, respondents were asked to indicate which types of services were provided by their program within the four risk domains: individual, family, school, and community.

Individual Domain

Exhibit 3-82 presents the findings on services provided by programs in the Commonwealth. In the Commonwealth, over half of respondents reported that the following individual domain services were provided by their programs:

- Life Skills/Social Skills Training (66.7%);

- Mentoring (54.4%); and

- Youth Community Service Programs (e.g., volunteer work and service learning [51.4%]).

Between 25 percent and 50 percent of all respondents indicated that their programs provided the following:

- Peer Leadership (42.9%);

- Career/Job Skills Training (39.1%);

- Drug-Free Social Activities (38%);

- After-School Recreation Services (37.4%);

- Intergenerational Services (32%);

- Tutoring (31.4%); and

- Youth Community Action Groups (29.2%).

The least common service reported was Teen Drop-In Centers (11.3%).

Exhibit 3-82. Commonwealth Programs/Services Provided by Prevention Programs—Individual Domain: Phase II Respondents
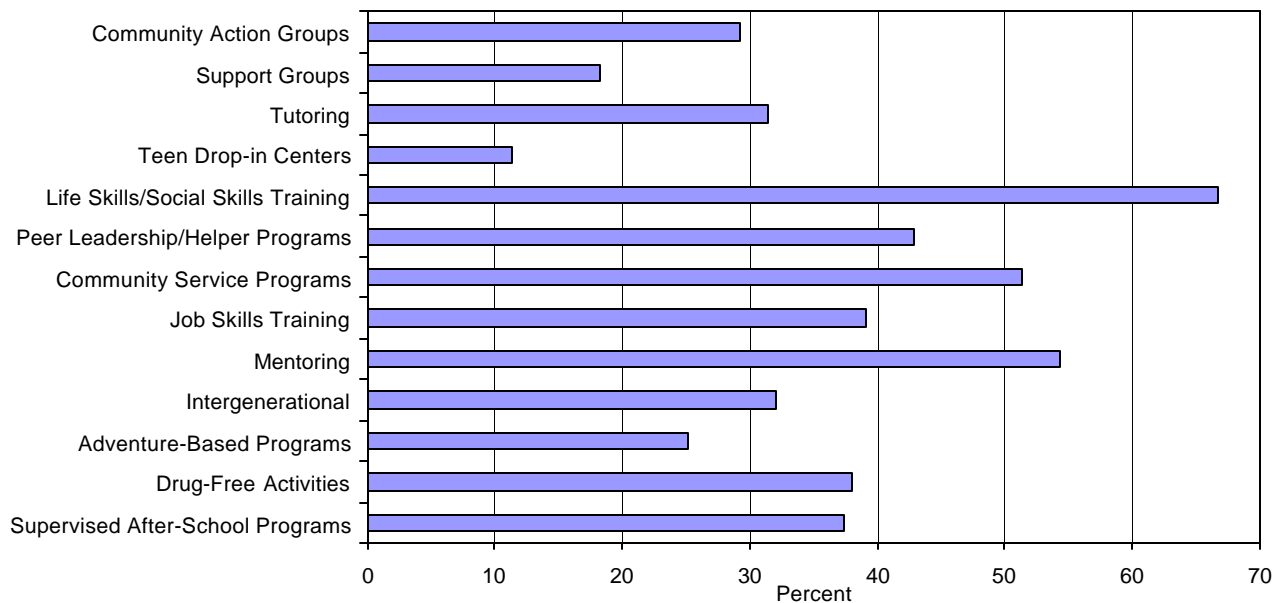
Exhibit 3-83 presents the findings for HPR I. The pattern of results in HPR I was found to be similar to the Commonwealth results. More than 50 percent of respondents in HPR I reported that their programs provided the following services:

- Life Skills/Social Skills Training (65.6%);

- Youth Community Service Programs (51.6%); and

- Mentoring (50%).

The least common service reported by respondents was Teen Drop-In Centers (6.1%).

**Exhibit 3-83. HPR I Programs/Services Provided by Prevention Programs—
Individual Domain: Phase II Respondents**
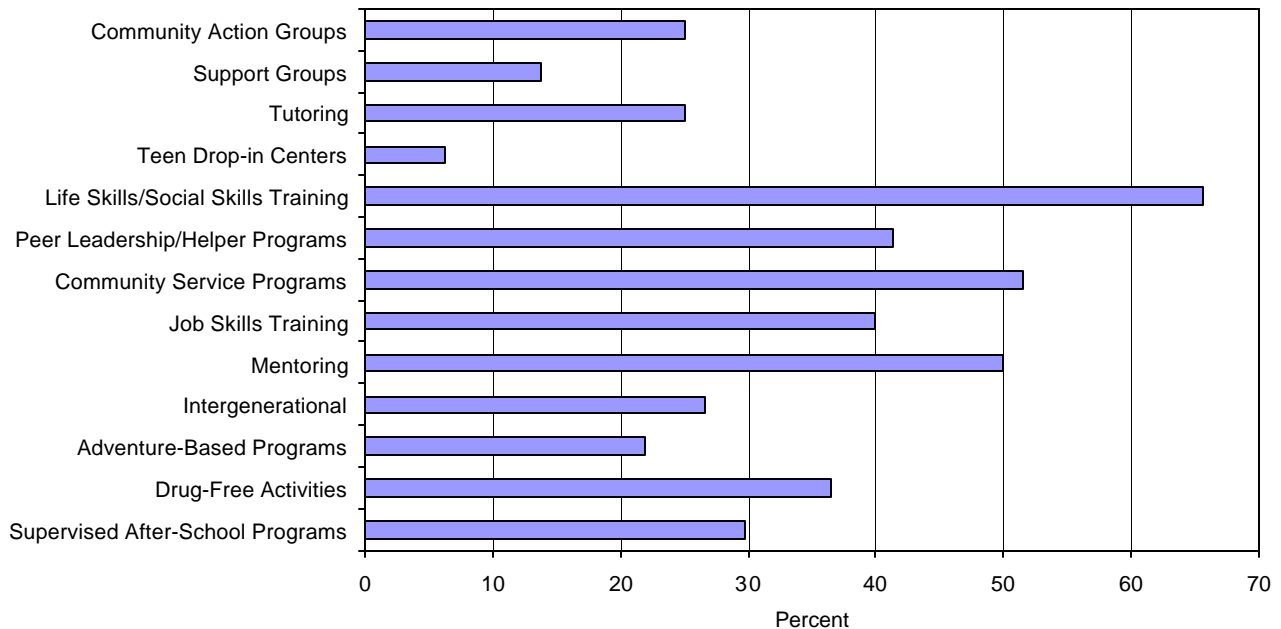
Exhibit 3-84 presents the findings for HPR II. The most common individual domain service reported by respondents was Life/Social Skills Training (61.3%), followed by Youth Community Service Programs (46.7%) and Mentoring (46.7%). The least common service reported by respondents was Support Groups (16%).

**Exhibit 3-84. HPR II Programs/Services Provided by Prevention Programs—
Individual Domain: Phase II Respondents**
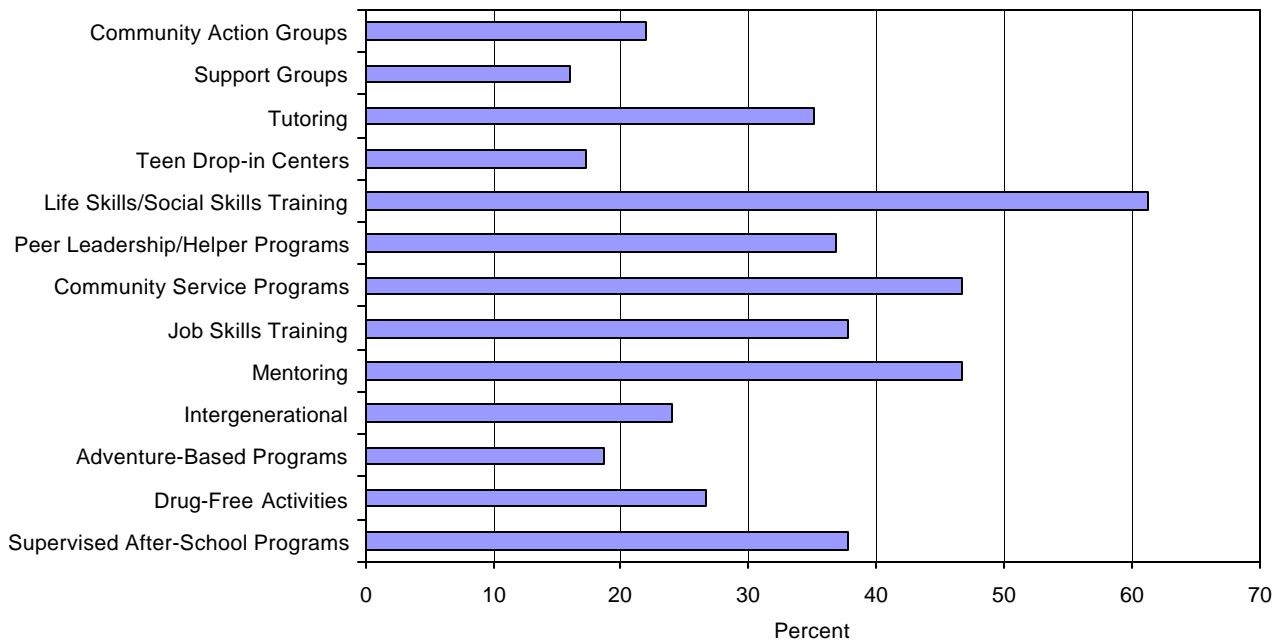
Exhibit 3-85 presents the findings for HPR III. The most common service reported by respondents in HPR III was Life Skills/Social Skills Training (72%), followed by Mentoring (60.5%). The least common service reported by respondents in HPR II was Teen Drop-In Centers (10.7%).

Exhibit 3-85. HPR III Programs/Services Provided by Prevention Programs—Individual Domain: Phase II Respondents
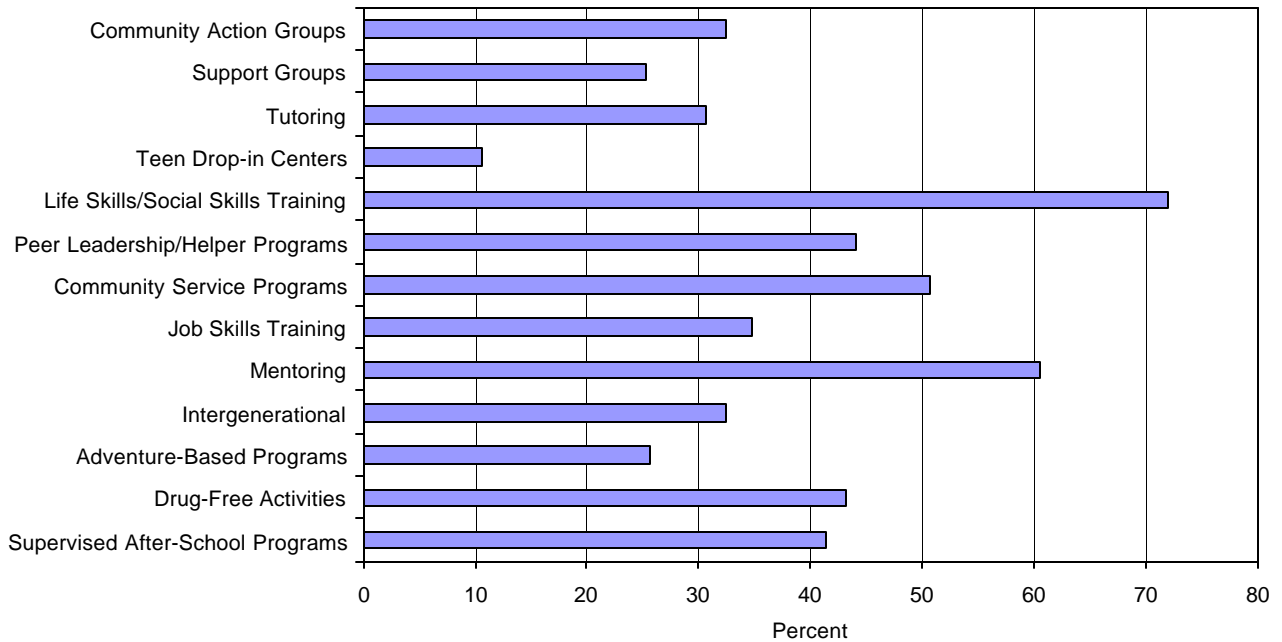
Exhibit 3-86 presents the findings for HPR IV. The majority of respondents reported that their programs provided Life Skills/Social Skills Training (77.6%), the most commonly reported service reported in the individual domain. The second most commonly reported service was Mentoring (69%), followed by Community Service Services (57.9%) and Peer Leader/Helper Services (56.9%). The least common service provided by programs was Teen-Drop In Centers (10.3%).

**Exhibit 3-86. HPR IV Programs/Services Provided by Prevention Programs—
Individual Domain: Phase II Respondents**
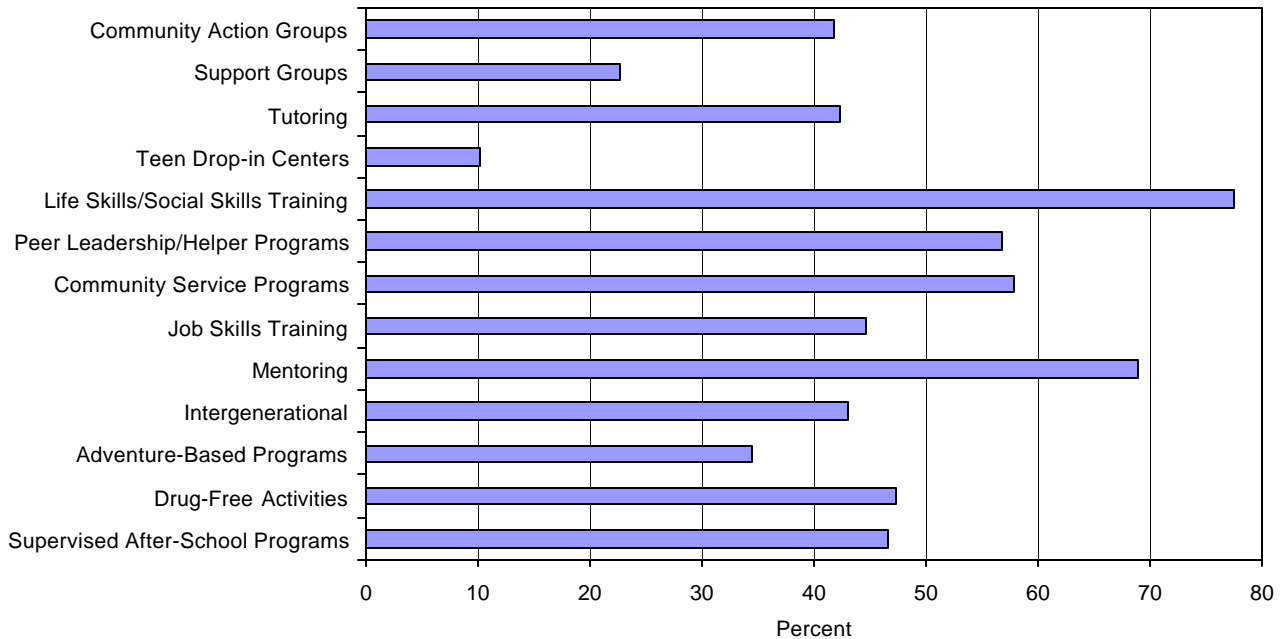
Exhibit 3-87 presents findings for HPR V. As with the other HPRs, the most common service provided by programs in HPR V was Life Skills/Social Skills Training (61.5%). The second most commonly reported service in the individual domain was Community Service Programs (57.6%), followed by Mentoring (50.8%).

**Exhibit 3-87. HPR V Programs/Services Provided by Prevention Programs—
Individual Domain: Phase II Respondents**
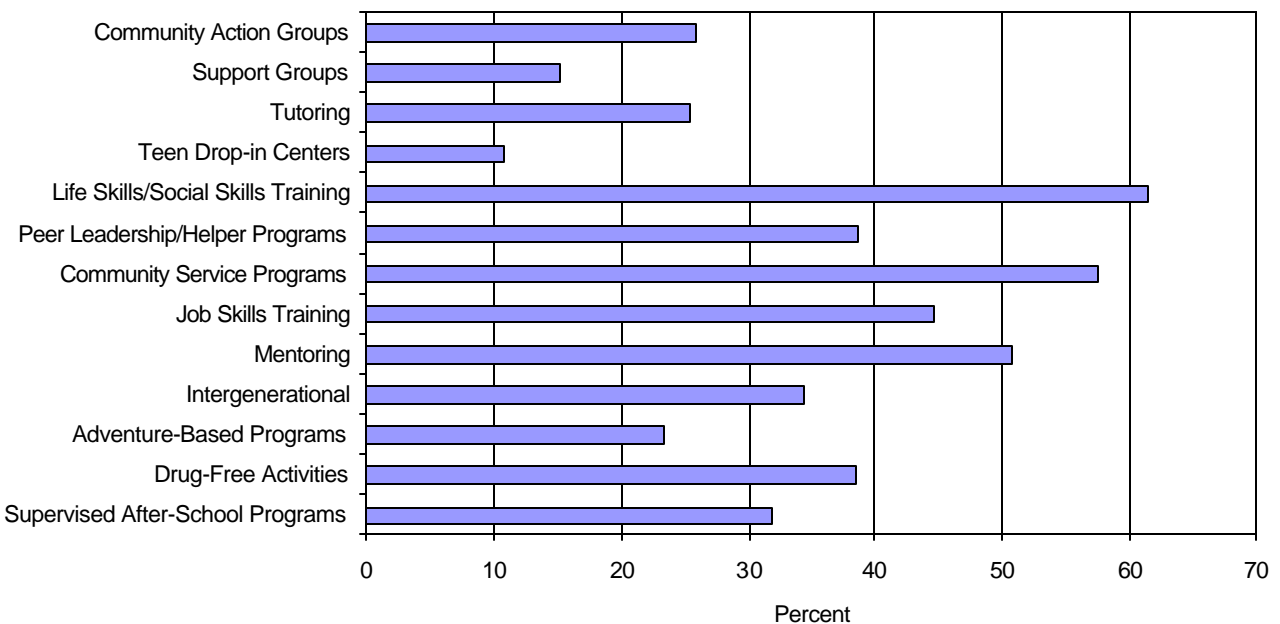
Family Domain

Exhibit 3-88 presents the findings on family domain services provided in the Commonwealth. More than 50 percent of the respondents in the Commonwealth reported that their programs provide the following services:

- Parenting/Family Management Training (58.5%); and

- Family Support (e.g., family planning, home visits, etc., 50.6%).

The least common family domain service provided by programs in the Commonwealth was PreMarital Counseling (7.1%).

Exhibit 3-88. Commonwealth Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
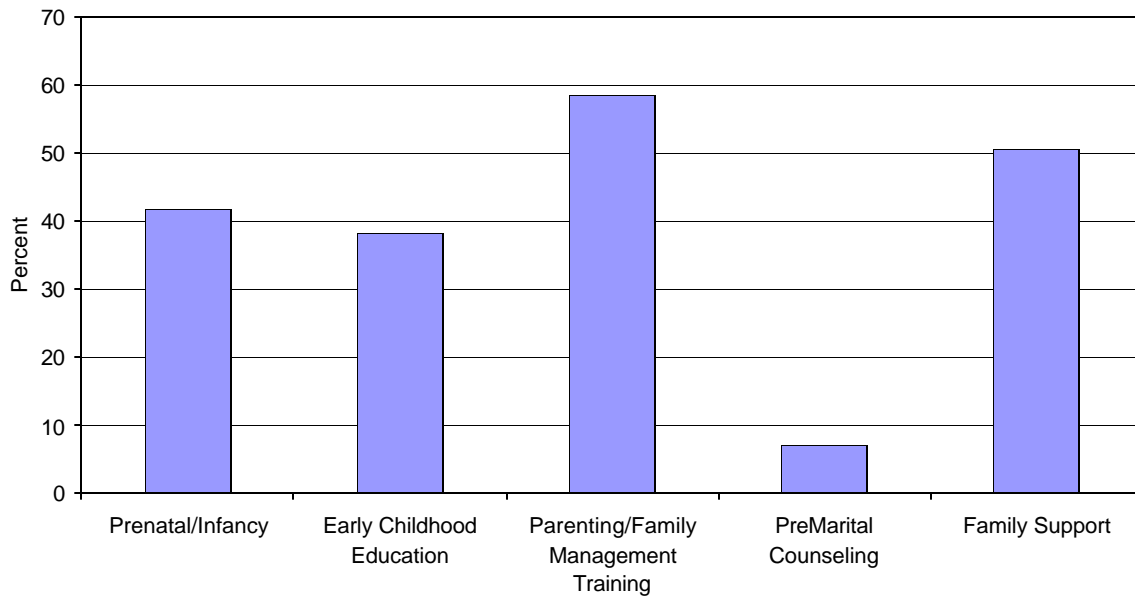
Exhibit 3-89 presents the findings for HPR I. More than 50 percent of the respondents in HPR I reported their programs provided Parenting/Family Management Training (53.3%), followed by Family Support (45.2%).

Exhibit 3-89. HPR I Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
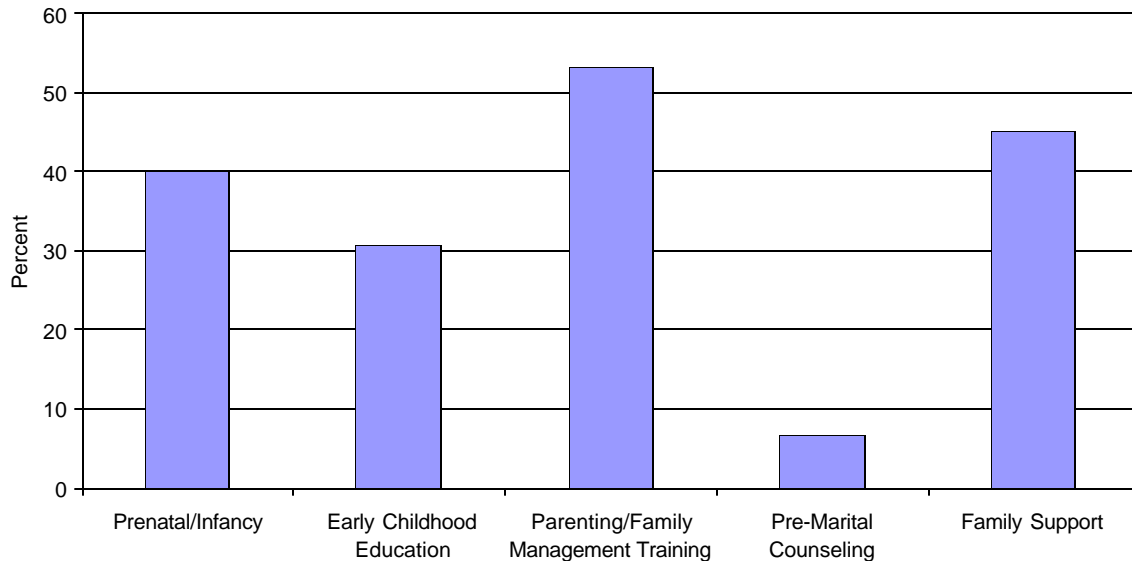
Exhibit 3-90 presents the findings for HPR II. More than 50 percent of the respondents in HPR II reported that Parenting/Family Management Training was a service provided by their programs (52%), followed by Family Support (42.7%).

Exhibit 3-90. HPR II Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
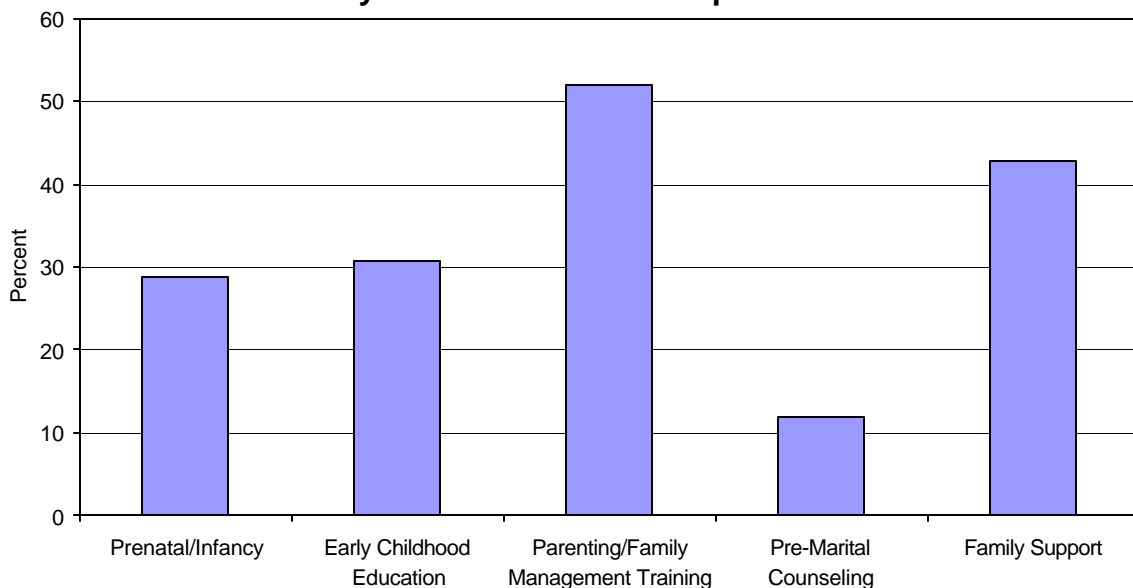
Exhibit 3-91 presents the findings for HPR III. More than 50 percent of the respondents in HPR III reported that Parenting/Family Management Training (63.2%) and Family Support (56.6%) were services provided by their programs.

Exhibit 3-91. HPR III Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
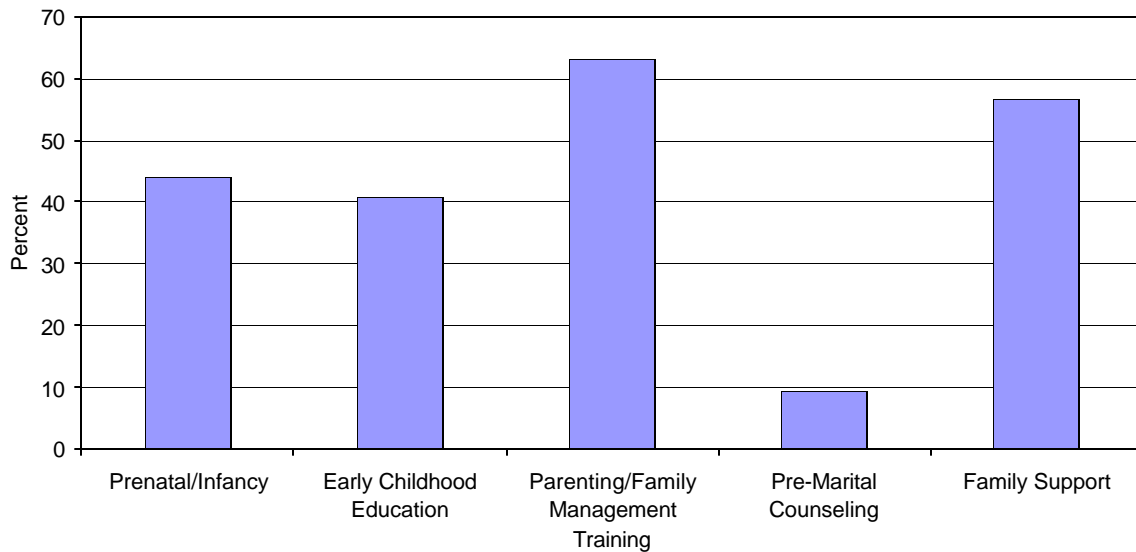
Exhibit 3-92 presents the findings for HPR IV. More than 50 percent of respondents in HPR IV reported that Parenting/Family Management Training (63.8%) and Family Support (60.0%) were services provided by their programs.

Exhibit 3-92. HPR IV Programs/Services Provided by Prevention Programs—Family Domain: Phase II Respondents
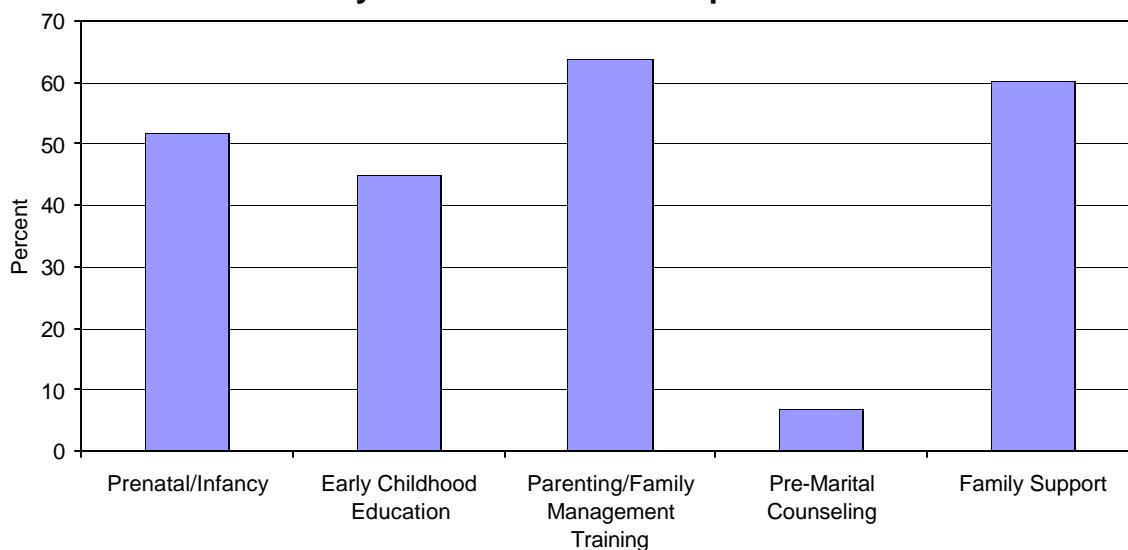
Exhibit 3-93 presents the findings for HPR V. As with the other HPRs, the most common service provided by programs in the family domain was Parenting/Family Management Training (62.7%). The second most commonly reported service by respondents in HPR V was Family Support Services (53.1%).

**Exhibit 3-93. HPR V Programs/Services Provided by Prevention Programs—
Family Domain: Phase II Respondents**
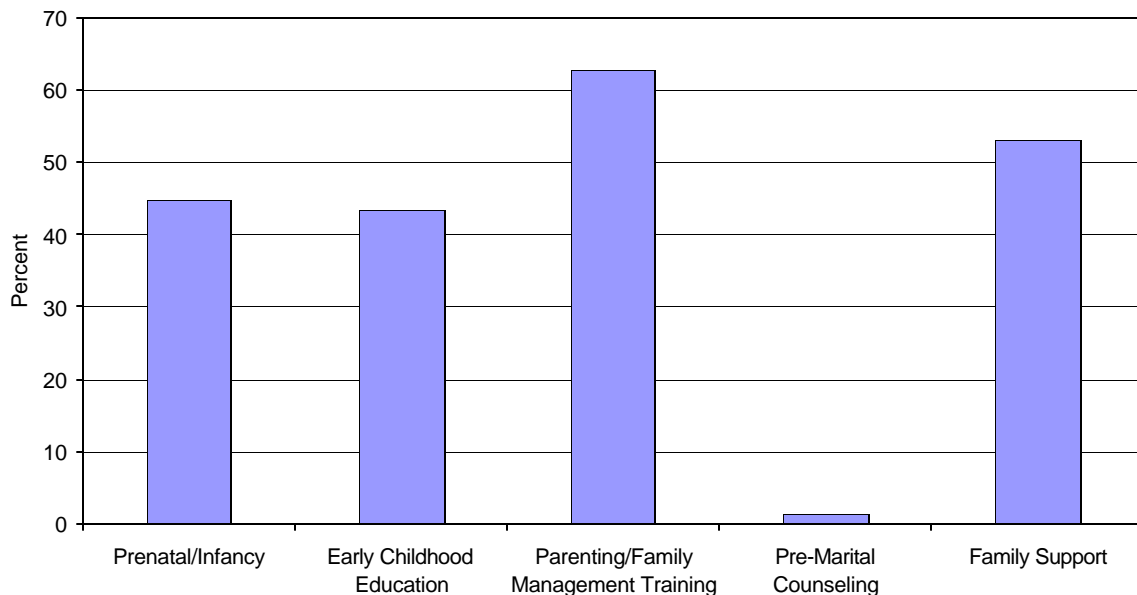
School Domain

Exhibit 3-94 presents the findings for services provided by the Commonwealth within the school domain. In the Commonwealth, less than 50 percent of respondents reported that they provided any of the services within the school domain. The most commonly reported service in the school domain was Organizational Change in the Schools Through the Development of School-Community Partnerships or School Management Teams (43.1%).

Less than one-third of all respondents indicated that their programs provided:

- Enforcement of School Policies That Discourage Substance Abuse (31.3%);

- School Behavior Management (29.2%);

- Classroom Organization, Management, and Instructional Practices (28.8%); and

- Development of School Policies That Discourage Substance Abuse (26.3%).

Only 12 percent of respondents indicated that their program provided School Transition Services.

**Exhibit 3-94. Commonwealth Programs/Services Provided by Prevention Programs—
School Domain: Phase II Respondents**
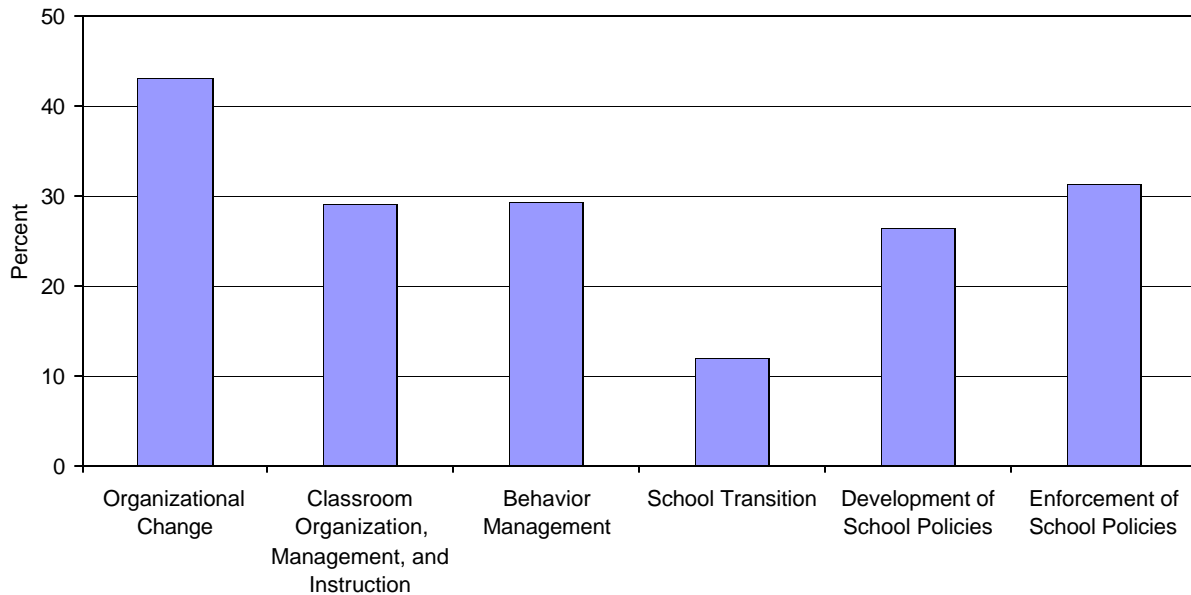
Exhibit 3-95 presents the findings for HPR I. The most common school domain service reported by respondents in HPR I was Organizational Change (41.3%). Only 12 percent of respondents in HPR I reported providing School Transition Services, the least common service provided by HPR I programs.

**Exhibit 3-95. HPR I Programs/Services Provided by Prevention Programs—
School Domain: Phase II Respondents**
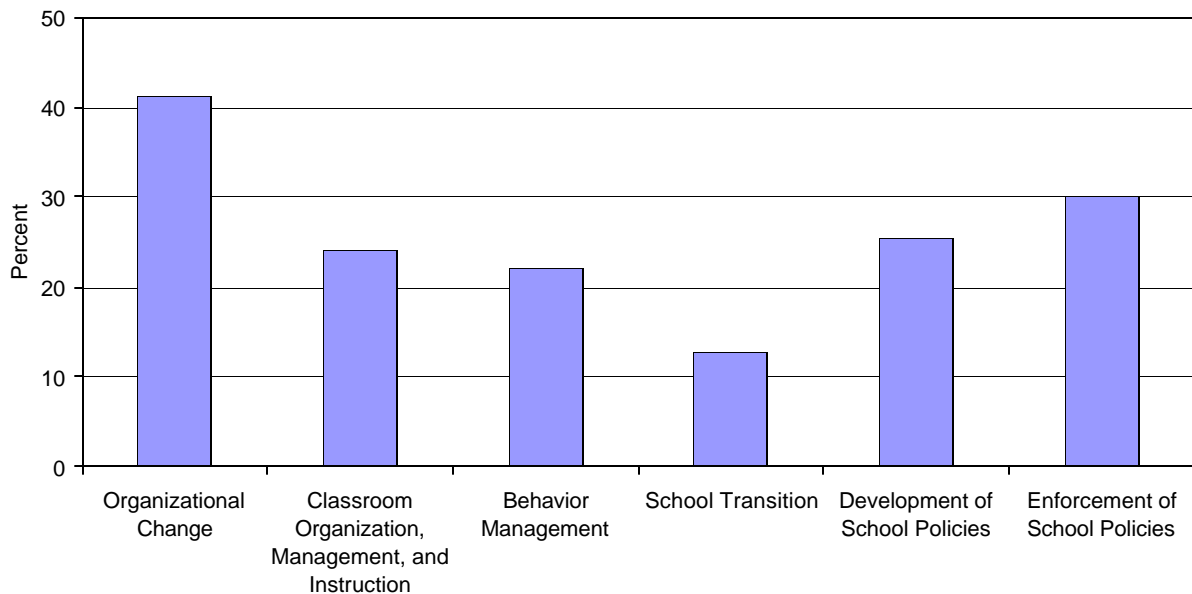
Exhibit 3-96 presents the findings for HPR II. The most common service provided by programs in HPR II was Organizational Change (34.7%). The second most common service reported by respondents was Behavior Management (29.3%). Similar to the findings obtained for HPR I, the least common service in the school domain was School Transition (8.1%).

Exhibit 3-96. HPR II Programs/Services Provided by Prevention Programs— School Domain: Phase II Respondents
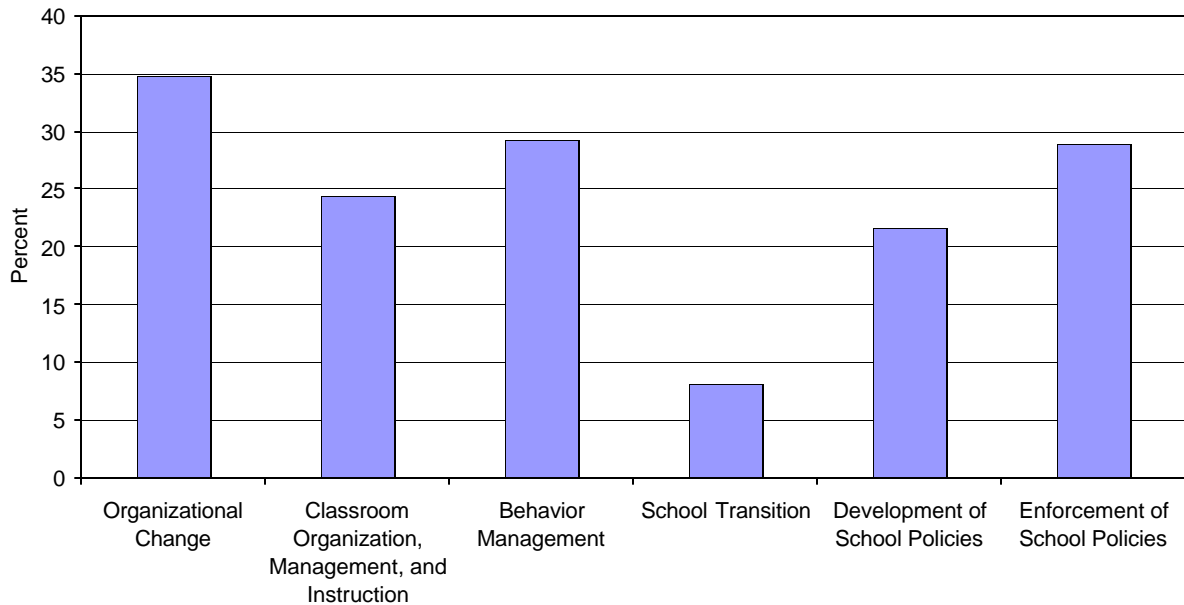
Exhibit 3-97 presents the findings for HPR III. The most common service reported by respondents in HPR III was Organizational Change (41.9%), followed by Behavior Management (33.8%) and the Enforcement of School Policies Against ATOD Use (33.8%). The least common service provided by programs in HPR III was School Transition (17.3%).

Exhibit 3-97. HPR III Programs/Services Provided by Prevention Programs—School Domain: Phase II Respondents
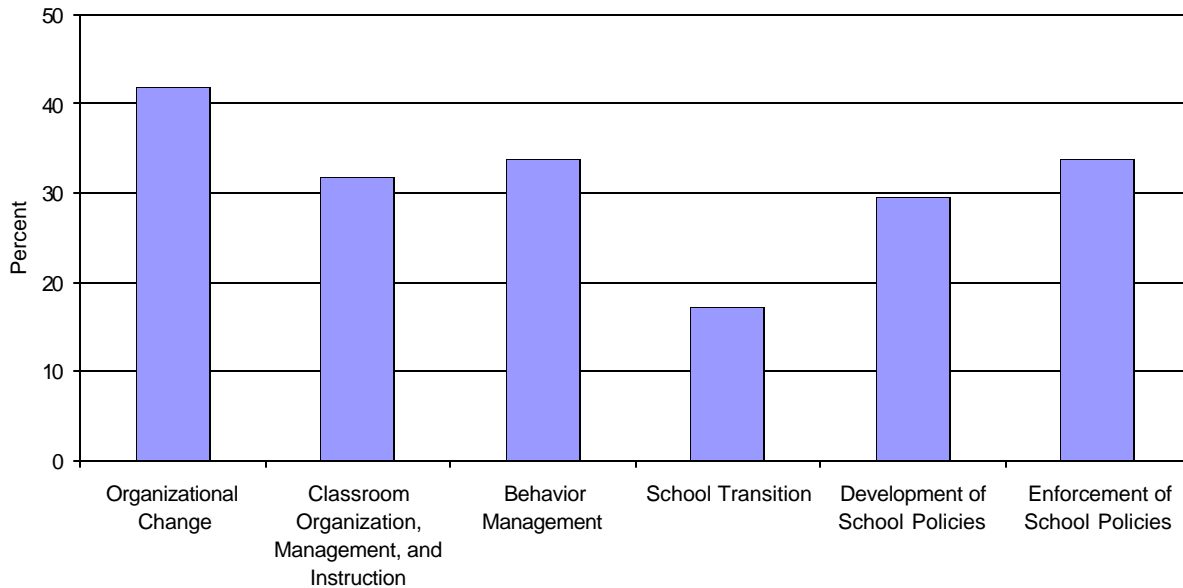
Exhibit 3-98 presents the findings for HPR IV. The most common service reported by respondents in HPR IV was the provision of Organizational Change Services (50%). Unlike the other HPRs, the second most commonly reported service was Classroom Organization, Management, and Instruction (37.3%).

Exhibit 3-98. HPR IV Programs/Services Provided by Prevention Programs—School Domain: Phase II Respondents
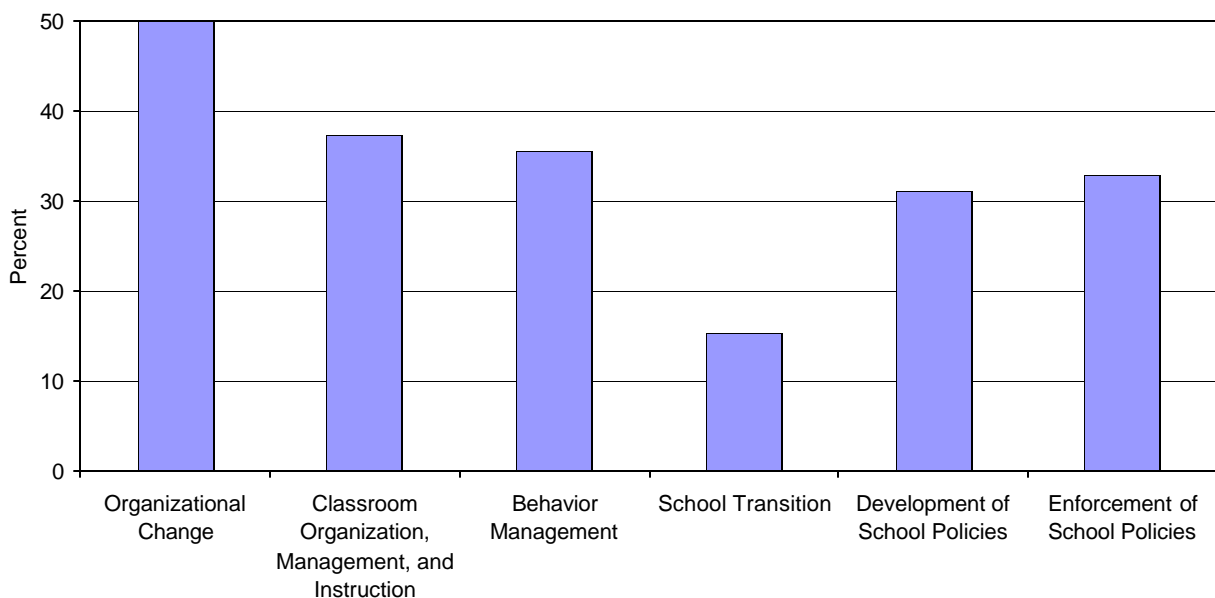
Exhibit 3-99 presents the findings for HPR V. The most common service reported by respondents in HPR IV was the provision of Organizational Change Services (44.6%), followed by the Enforcement of School Policies Against ATOD use (27.3%).

Exhibit 3-99. HPR V Programs/Services Provided by Prevention Programs— School Domain: Phase II Respondents
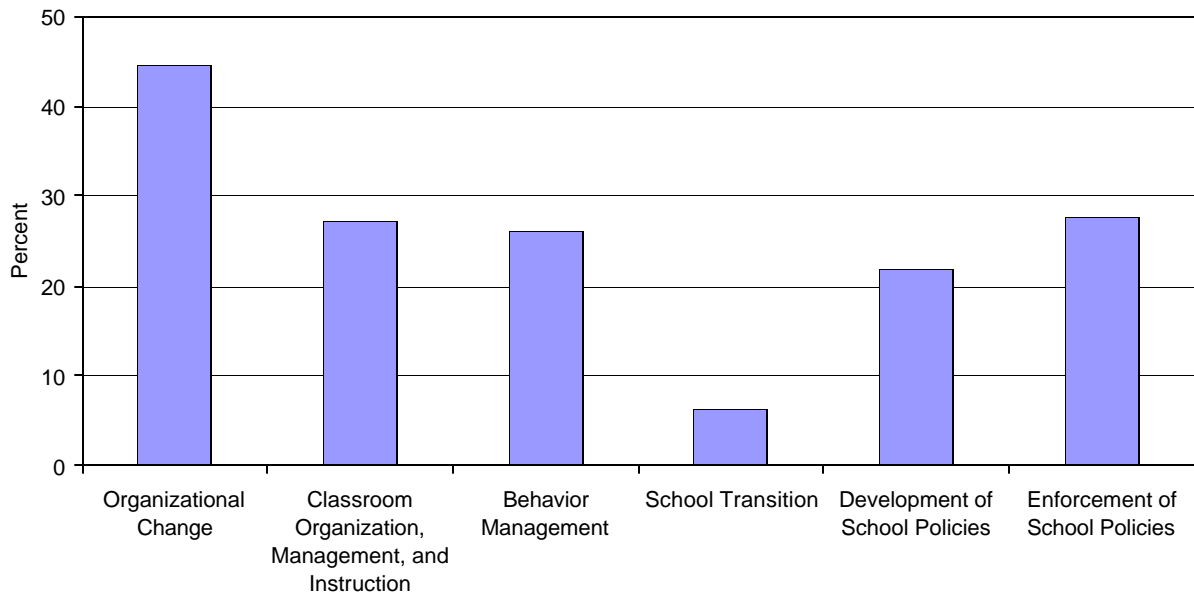
Community Domain

Exhibit 3-100 presents the findings for the Commonwealth on service provision in the community domain. More than 50 percent of respondents in the Commonwealth reported providing the following services:

- Information Dissemination (77.8%);

- Media Campaigns (56.7%); and

- Community Development/Capacity Building (52.1%).

Between 30 percent and 50 percent of respondents indicated that their programs provide services regarding the enforcement of Community Laws and Policies That Discourage Substance Abuse (32.6%), and Community Mobilization (47.8%).

Respondents were less likely to report that their programs provide assistance with Community Policing Services (23.0%).

Exhibit 3-100. Commonwealth Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
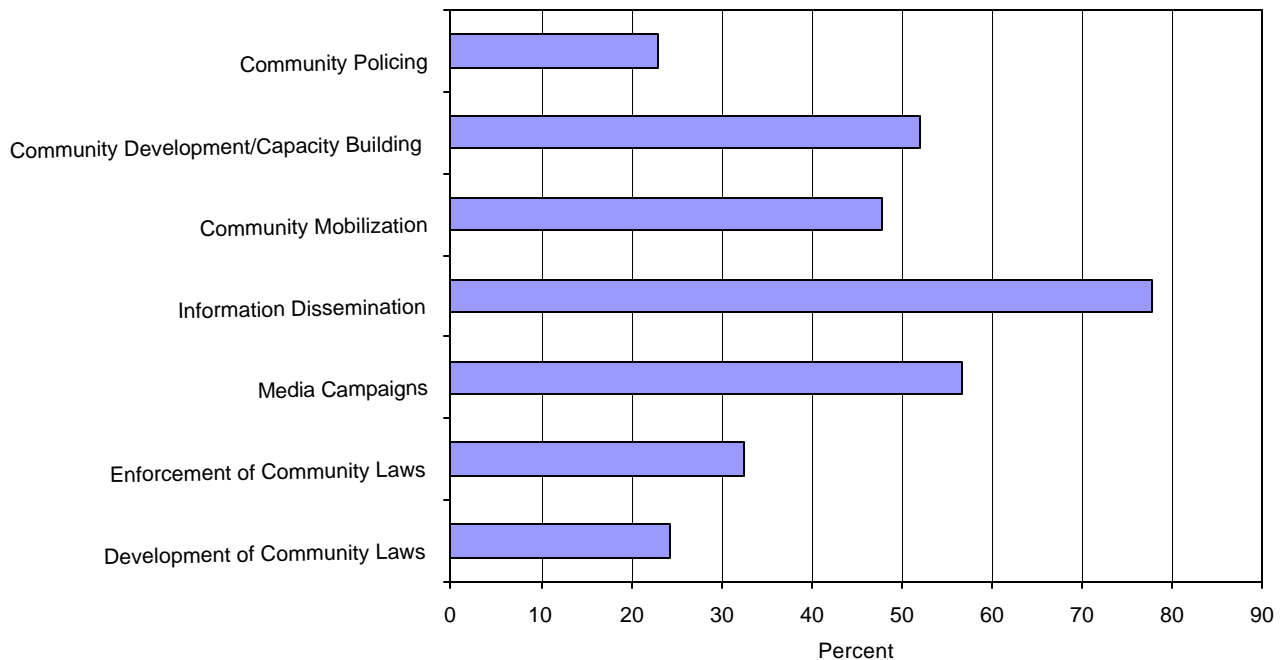
Exhibit 3-101 presents the findings for HPR I. Similar to the findings for the Commonwealth, the most commonly reported services provided by programs in HPR I were Information Dissemination (77.1%) and Media Campaigns (61.9%). The least common service was Community Policing (15.6%).

Exhibit 3-101. HPR I Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
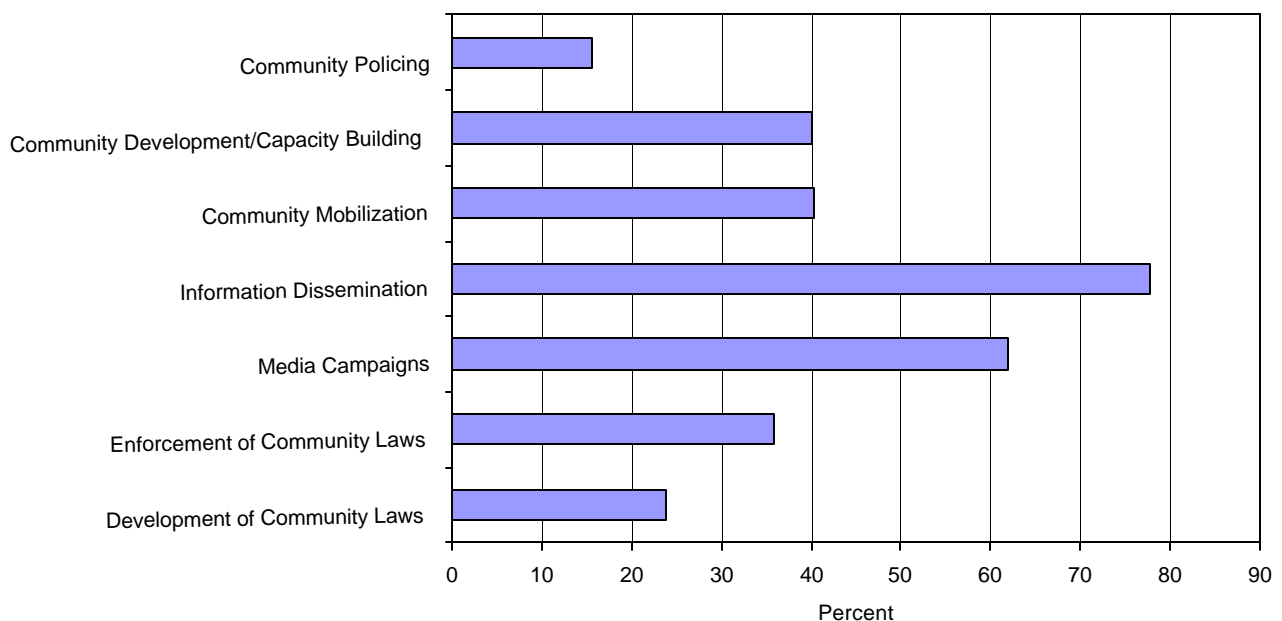
Exhibit 3-102 presents the findings for HPR II. The most common service provided by programs in HPR II was Information Dissemination (77.3%), followed by Community Capacity Building (54.7%). The least commonly reported service in the community domain was the Development of Community Laws or Policies That Discourage ATOD Use (23.3%).

Exhibit 3-102. HPR II Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
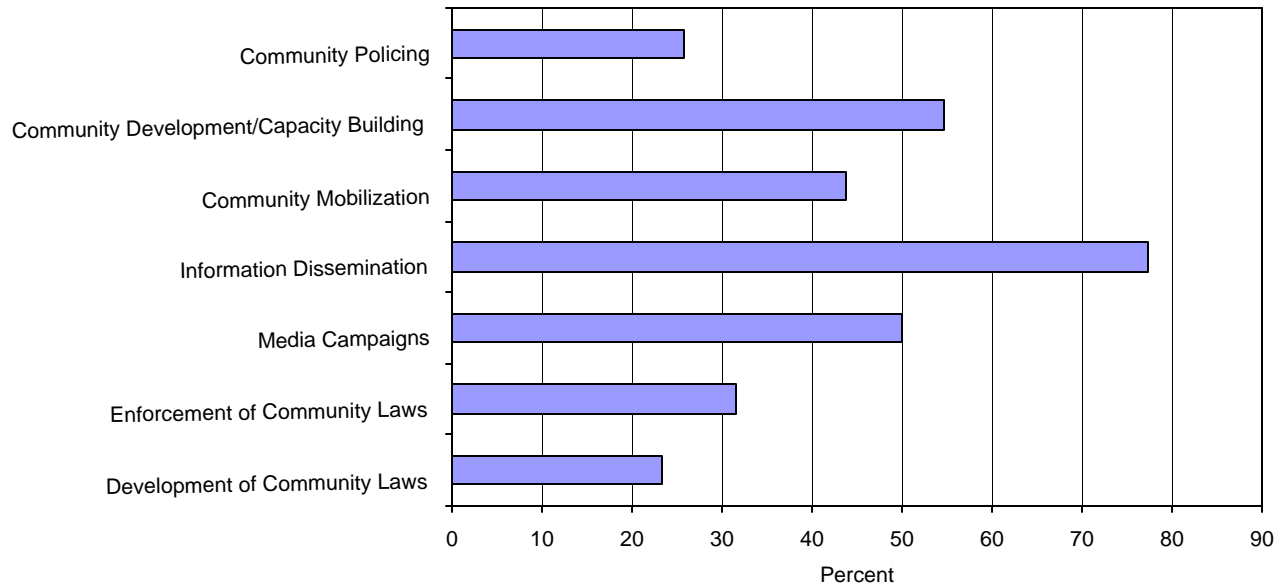
Exhibit 3-103 presents the findings for HPR III. The majority of respondents in HPR III reported that Information Dissemination (85.7%) and Media Campaigns (63.2%) were provided by their programs. The least common service reported by respondents was Community Policing (23.7%).

Exhibit 3-103. HPR III Programs/Services Provided by Prevention Programs— Community Domain: Phase II Respondents
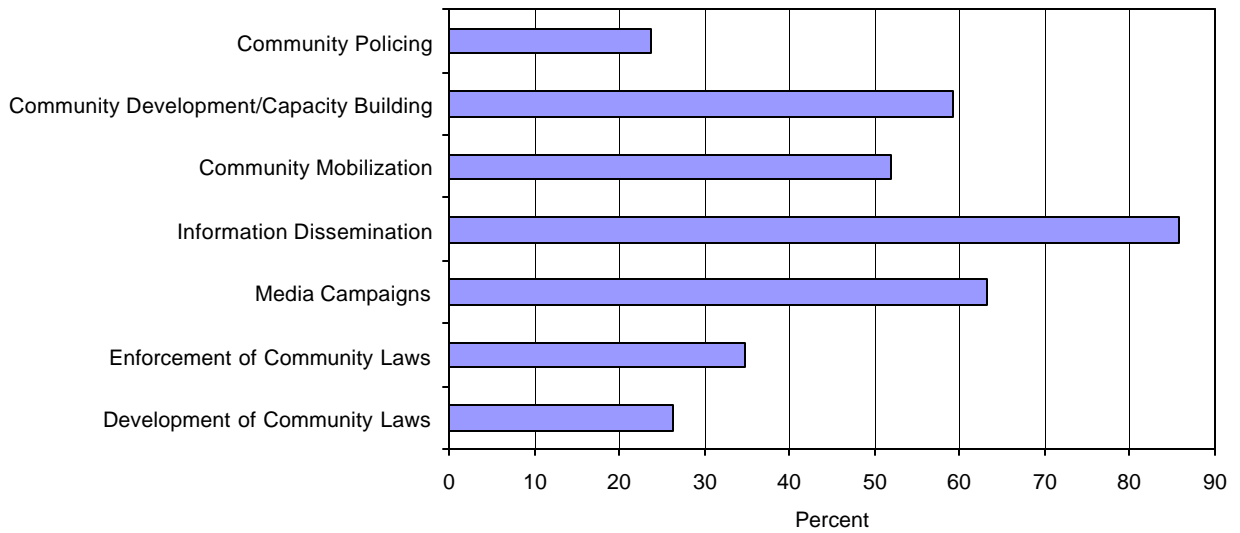
Exhibit 3-104 presents the findings for HPR IV. Eighty percent of respondents reported that their programs provided Information Dissemination services in HPR IV followed by Media Campaigns (57.36%). The least common service provided by programs in HPR IV was Community Policing (24.6%).

Exhibit 3-104. HPR IV Programs/Services Provided by Prevention Programs— Community Domain: Phase II Respondents
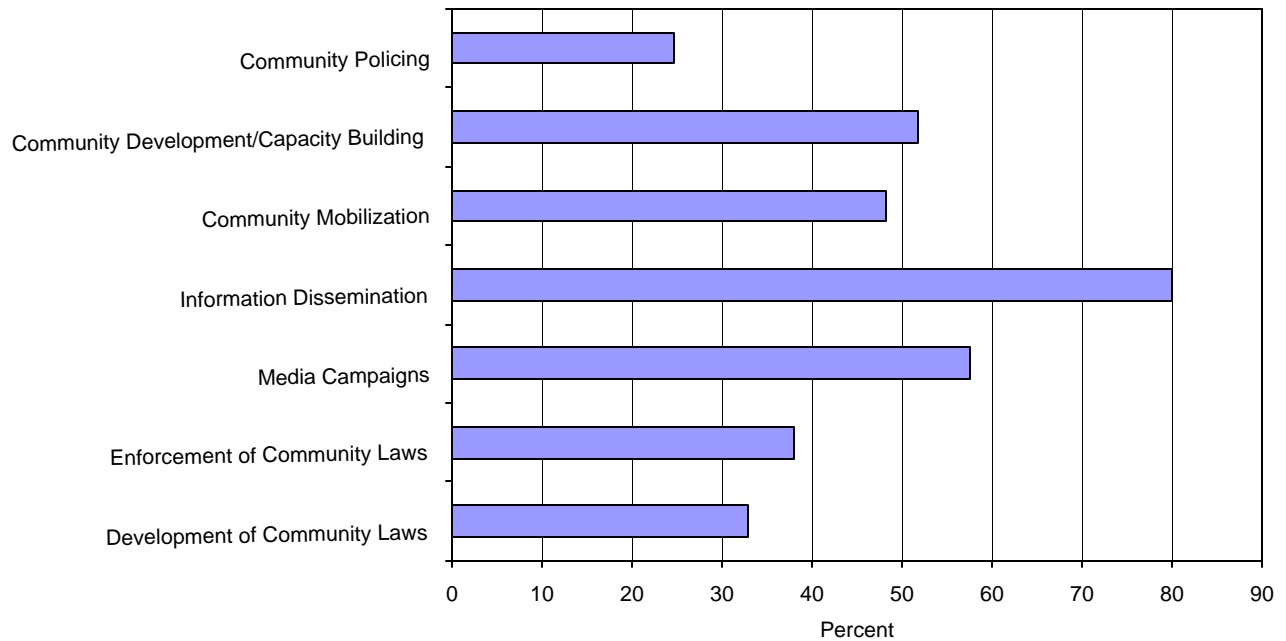
Exhibit 3-105 presents the findings for HPR V. Similar to the other HPRs, the most commonly reported community domain services in HPR V were Information Dissemination (71.2%) and community Capacity Development (52.3%). The least common service reported by respondents was the Development of Community Laws and Policies That Discourage ATOD Use (18.2%).

Exhibit 3-105. HPR V Programs/Services Provided by Prevention Programs—Community Domain: Phase II Respondents
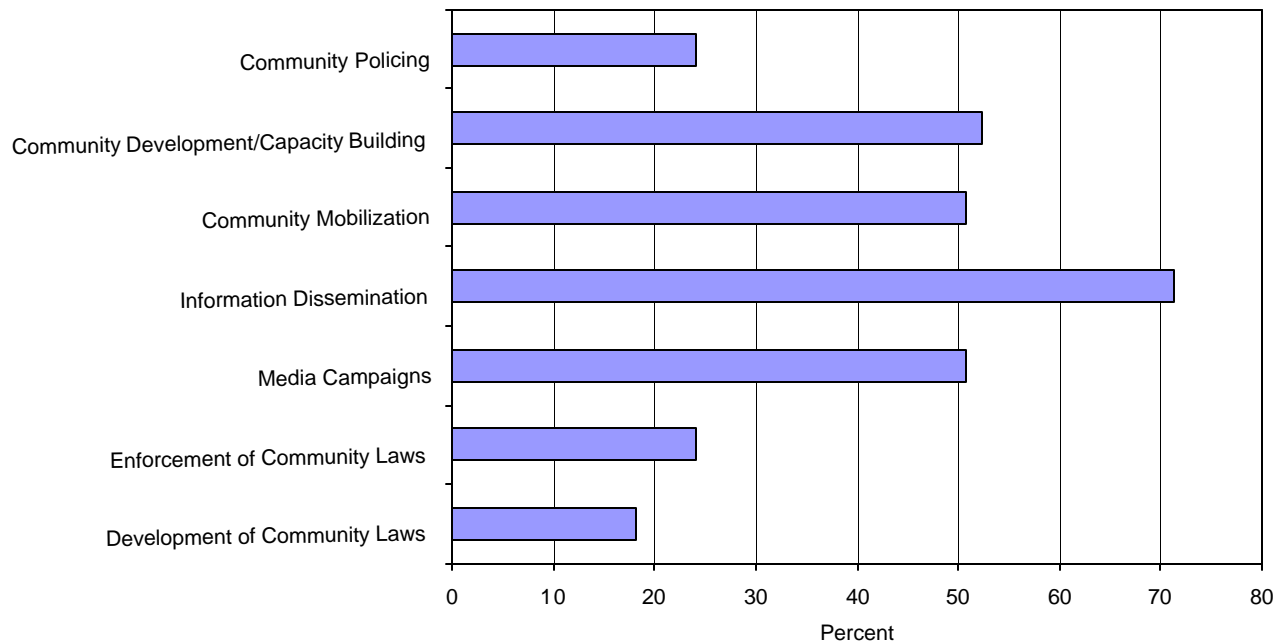
3.2.5.2 *Program Intensity*

To collect information on program intensity, respondents were asked to indicate how many weeks their program operated during the past 12 months, the average session length, and the average number of meetings per week or month. Responses to these questions were quite diverse due to the wide range of programs provided across the Commonwealth.

Program Length

Exhibit 3-106 presents the findings on the average number of weeks during the past 12 months a program provided prevention services. On average, in the Commonwealth, respondents reported that their programs operated 42.62 weeks during the past 12 months, with a range of 6 to 52 weeks. Again, the wide range of responses is due to the types of programs provided by respondents. For example, a number of respondents who manage programs such as health clinics reported that their programs operate 52 weeks of the year, 7 days a week.

**Exhibit 3-106. Average Number of Weeks a Program Operated
in the Past 12 Months: Phase II Respondents**

	No. of Weeks Operated	
	Average	Range
Commonwealth	42.62	6–52
HPR I	39.37	9–52
HPR II	42.54	8–52
HPR III	42.04	6–52
HPR IV	44.71	10–52
HPR V	46.25	9–52

Similar results were found across the five HPRs. The average number of weeks respondents reported a program operated within the last 12 months in HPR I was 39.37, with a range of 9 to 52 weeks. In HPR II, the average number of weeks a program operated was 42.54, with a range of 8 weeks to 52 weeks. In HPR III, the average number of weeks a program operated was 42.04, with a range of 6 to 52 weeks. In HPR IV, the average number of weeks a program operated was 44.71, with a range of 10 to 52 weeks. In HPR V, the average number of weeks a program operated was 46.25, with a range of 9 to 52 weeks.

Session Length

Exhibit 3-107 presents the findings on the average length of each program/activity session. On average in the Commonwealth, respondents reported that the average length of each session was 5.41 hours, with a range of .5 hours to 80 hours. Again, the wide range of responses is due to the wide variety of programs offered in the Commonwealth. Respondents who reported very long session lengths typically managed programs that provided a one-time service, such as Health Care Services, to different clients. In contrast, shorter sessions typically involved programs that provided services to the same clients over a period of time, such as a Life Skills Training programs offered in the schools.

Exhibit 3-107. Average Program Session Length: Phase II Respondents

	No. of Hours	
	Average	Range
Commonwealth	5.41	.5–80
HPR I	9.69	.5–80
HPR II	6.04	1–60
HPR III	3.17	1–14
HPR IV	4.66	1–24
HPR V	3.12	1–20

The average length of each session reported by respondents varied by HPR. Respondents in HPRs I and II reported a wider range of program length (range = .50 to 80 hours and 1.0 to 60.0 hours, respectively) compared with HPRs III, IV, and V (range = 1 to 14 hours, 1 to 24 hours, and 1 to 20 hours, respectively). The average length of program sessions was significantly longer in HPRs I and II (9.69 and 6.04 hours, respectively) compared with HPRs III, IV, and V (3.17, 4.66, and 3.12 hours, respectively).

3.2.6   *Budget*

To obtain information on prevention budgets, respondents were asked to estimate the annual budget for their program in the past year. Exhibit 3-108 presents the findings on the average annual budget reported by Phase II respondents for prevention programs in the Commonwealth. The median reported budget for prevention programs in the Commonwealth was $145,000, with an average of $535,851 and a range of $1,000 to $18,000,000.* HPRs II and V reported the highest median annual budget, $200,000. HPR II had an average annual budget of $1,176,575 and a range of $1,500 to $18,000,000. HPR V had an average annual budget of 393,850, with a range of $3,000 to 2,850,000. The lowest reported median annual budget was in HPR I, $80,000, with an average annual budget of $182,757, and a range of $1,000 to $2,251,510. The median annual budget in HPR III was 110,000, with an average of 388,497 and a range of $5,000 to $4,754,281. In HPR IV, the median annual reported budget was $121,902, with an average of $460,032 and a range of $4,000 to $5,000,000.

Exhibit 3-108. Average Annual Program Budget

	Program Budget		
	Average	**Median**	**Range**
Commonwealth	$535,851	$145,000	$1,000–18,000,000
HPR I	$182,757	$80,000	$1,000–2,251,510
HPR II	$1,176,575	$200,000	$1,500–18,000,000
HPR III	$388,497	$110,000	$5,000–4,754,281
HPR IV	$460,032	$121,902	$4,000–5,000,000
HPR V	$393,850	$200,000	$3,000–2,850,000

3.2.7   *Staff*

To assess human resources, respondents were asked to indicate the number of full-time, part-time, and volunteer workers employed in their program, and the average number of hours per week worked by staff.

---

* Annual budget information was provided by survey respondents. The respondents may not have been program administrators with day-to-day knowledge of program budgets. In some cases where unusually large budgets were reported (e.g. $18,000,000), the prevention programs were part of large multiservice county agencies, and respondents may have been reporting larger agency-wide budgets.

3.2.7.1 *Employees*

Exhibit 3-109 presents the findings on the average number of program staff. On average, respondents in the Commonwealth reported by far that the majority of paid workers were full-time adults: paid youth workers were relatively rare. In addition, respondents reported a larger number of adult volunteers compared to youth volunteers. Indeed, there were more adult volunteers than paid adult employees.

Exhibit 3-109. Average Number of Program Staff

	Full-time Adults		Full-time Youth		Part-time Adults		Part-time Youth		Adult Volunteers		Youth Volunteers	
	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range
Commonwealth	9.39	0–325	.08	0–6	3.85	0–175	.16	0–10	17.70	0–576	2.68	0–125
HPR I	9.49	0–325	.15	0–5	4.78	0–175	.08	0–5	10.83	0–576	3.93	0–75
HPR II	20.34	0–325	.05	0–2	5.53	0–175	.08	0–4	20.56	0–461	2.00	0–50
HPR III	15.80	0–325	.00	0–0	6.01	0–175	.16	0–5	17.70	0–300	2.85	0–100
HPR IV	12.12	0–325	.00	0–0	8.77	0–175	.42	0–10	14.19	0–230	1.01	0–12
HPR V	11.82	0–325	.21	0–6	7.04	0–175	.00	0–0	12.04	0–400	3.51	0–125

However, the number of staff varied widely by program. The range was 0 to 325 for full-time adult workers, 0 to 6 for full-time youth, 0 to 175 for part-time adults, 0 to 10 for part-time youth, 0 to 576 for adult volunteers, and 0 to 125 for youth volunteers.

The findings were similar across the five HPRs. Programs were more likely to report a larger number of full-time adult employees than any other paid category; youth employees, both full- and part-time, were relatively rare. However, programs often utilized adult volunteers. Indeed, there were more adult volunteers than full-time adult staff across the five HPRs.

3.2.7.2 *Employee Hours*

Exhibit 3-110 presents the findings on the average number of hours worked by program staff. In regards to hours worked by staff, not surprisingly, full-time (32.1) and part-time adult (11.17) staff worked more hours compared to other staff. Adult volunteer staff only worked 2.80 hours a week on average, with volunteer youth only working a half-hour per week. However, there is a wide range of responses regarding average number of hours worked due to the diversity of the programs.

Exhibit 3-110. Average Number of Hours Worked by Program Staff

	Full-time Adults		Full-time Youth		Part-time Adults		Part-time Youth		Adult Volunteers		Youth Volunteers	
	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range	Average	Range
Commonwealth	32.10	0–60	.60	0–40	11.17	0–35	.40	0–25	2.80	0–60	.51	0–30
HPR I	30.53	0–60	.86	0–20	8.87	0–35	.04	0–2	3.55	0–40	.81	0–18
HPR II	32.85	0–56	.60	0–38	12.30	0–35	.41	0–20	2.85	0–30	.31	0–5
HPR III	34.33	0–60	.00	0–0	11.72	0–35	.47	0–25	2.60	0–60	.17	0–3
HPR IV	31.89	0–50	.00	0–0	13.74	0–35	.96	0–20	2.40	0–20	.71	0–30

HPR V	32.20	0–55	1.70	0–40	9.97	0–35	.00	0–0	2.39	0–30	.57	0–15

In HPR I, the average number of hours worked by full-time staff was 30.53, with a range of 0–60. Part-time adults were reported to work on average 8.87 hours, with a range of 0–35 hours. In HPR II, full-time adult employees were reported to work 32.85 hours per week, with a range of 0–56 hours. Part-time staff were reported to work 12.30 hours per week on average, with a range of 0–35 hours. Respondents in HPR III reported that full-time adult staff worked 34.33 hours per week on average, with a range of 0–60 hours. Part-time adult staff worked an average of 11.72 hours per week, with a range of 0–35 hours. In HPR IV, full-time adults worked 31.89 hours per week on average, with a range of 0–50 hours. It was reported that part-time adults staff worked 13.74 hours per week on average, with a range of 0–35 hours. In HPR V, respondents reported that adult full-time staff worked 32.2 hours per week on average, with a range of 0-55 hours. Part-time adults were reported to work 9.97 hours per week on average, with a range of 0–35 hours.

3.2.7.3   *Credentials/Training*

To collect information on staff experience, respondents were asked if they had any prevention training experience, years of work experience in the prevention field, and years of work experience at the particular program for which they were currently working.

Staff Training

Exhibit 3-111 presents the findings on staff training. In the Commonwealth, over 60 percent of all program directors indicated that they had received some type of prevention training. Similar reports were found across the HPRs. At least half of all staff reported that they had received some type of prevention training. This value ranged from 58.1 percent in HPR I to 69.2 percent in HPR IV.

Exhibit 3-111. Percent of Phase II Respondents with Prevention Training
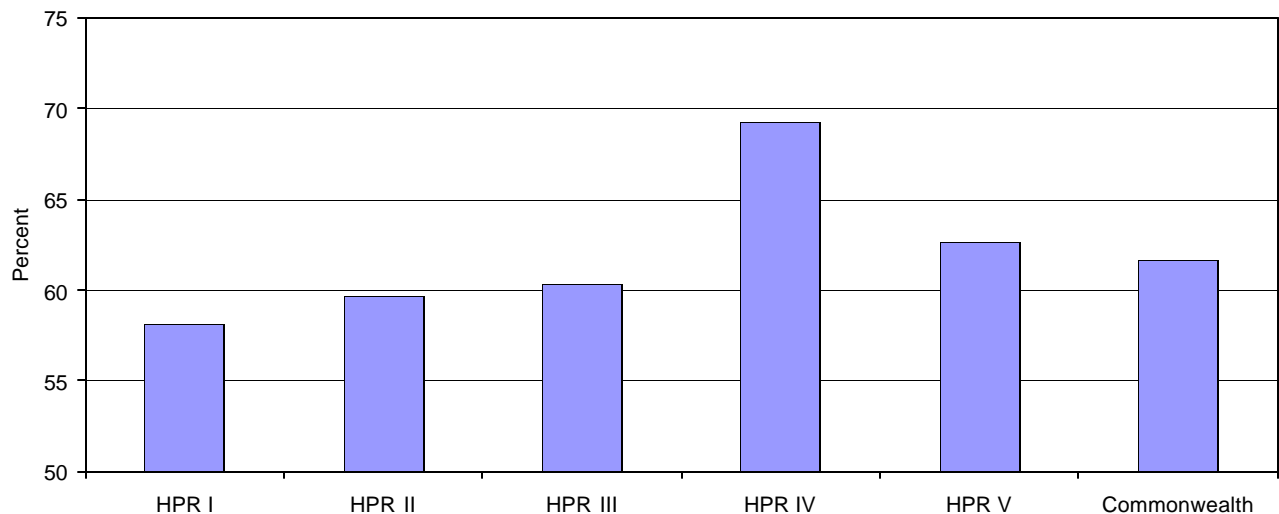
Staff Experience

Exhibit 3-112 presents the findings on length of time worked at their program and in the prevention field. On average, prevention directors reported that they had been program director/staff for 6.35 years with a range of .08 to 30 years. The length of time the respondent had worked at the program was relatively similar across HPRs. The average length of time fluctuated around 6 years in HPRs I (6.18 years), II (5.97 years), III (6.92 years), IV (6.12 years), and V (6.47 years).

Exhibit 3-112. Years Worked at Program and in the Prevention Field

	Years Worked at Program		Years Worked in the Prevention Field	
	Average	**Range**	**Average**	**Range**
Commonwealth	6.18	.25–30	13.34	.25–36
HPR I	6.18	.25–30	11.83	.25–35
HPR II	5.97	.08–26	15.07	2–35
HPR III	6.92	.25–30	13.67	.1–36
HPR IV	6.12	.16–23	13.75	1-32
HPR V	6.47	.25–26	12.79	2–33

The length of time respondents had worked in the prevention field was considerably longer than time working at a particular program. On average, respondents reported that they had worked in the prevention field for 13.34 years, with a range of .25 to 36 years. Work experience in the prevention field varied across the HPRs. Respondents in HPR II had more work experience, 15.07 years on average, compared to HPRs I (11.83 years) and V (12.79 years). Respondents in HPRs III (13.67 years) and IV (13.75) years had, on average, over 13 years of prevention experience.

3.2.8   *Data Collection and Evaluation*

To gather information on data collection and evaluation, respondents were asked to report uses of data, whether process and outcome evaluations were conducted, and if so, who conducted the evaluation(s) and when data were collected.

3.2.8.1   *Data Uses*

Respondents were asked to indicate the purposes, if any, for which their program used data. Exhibit 3-113 presents the findings for the Commonwealth. The overwhelming majority of respondents in the Commonwealth (93.0%) reported using data for at least one purpose. The following are the most commonly reported reasons for data utilization:

- Program planning (77.1%);
- Grant or contract proposals (73.4%);
- Outcome evaluation (68.0%);
- Funding requirements (63.0%); and
- Process evaluation (60.2%).

Exhibit 3-113. Commonwealth Programs' Use of Data: Phase II Respondents
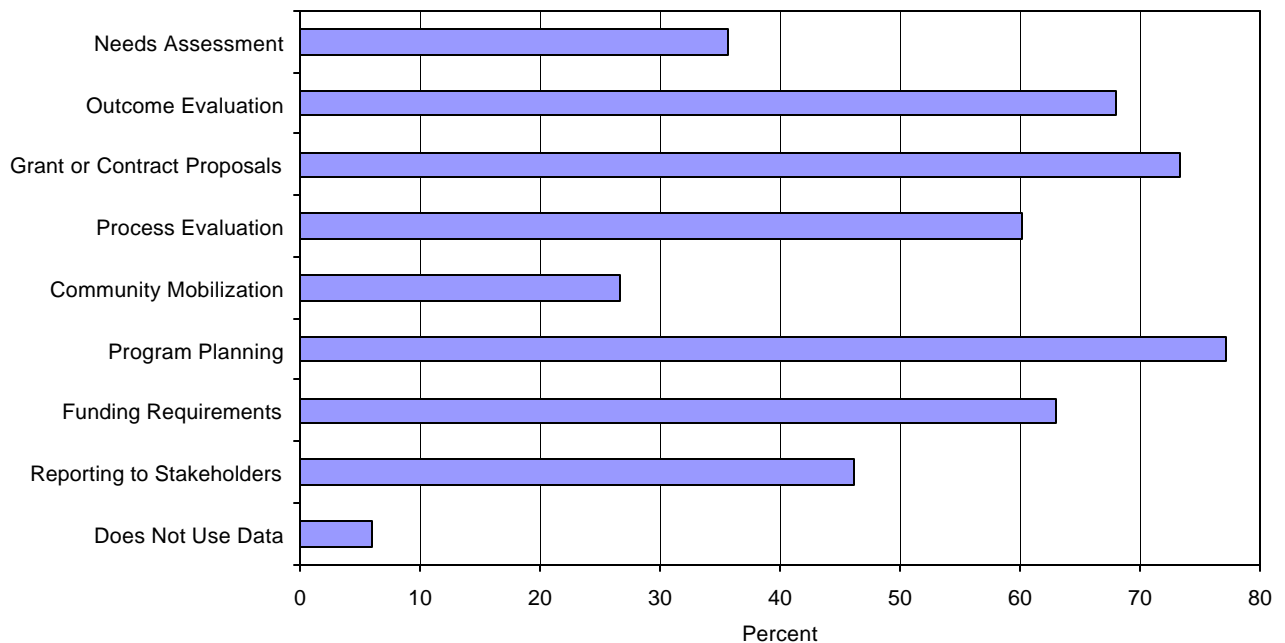
Exhibit 3-114 presents the findings for HPR I. A similar pattern of results was found in HPR I. The majority of respondents in HPR I (90%) reported using data for at least one purpose. The following are the most commonly reported reasons for data utilization:

- Program planning (69.4%);
- Outcome evaluation (69.4%);
- Grant or contract proposals (61.3%);
- Meet funding requirements (61.3%); and
- Process evaluation (50.0%).

Exhibit 3-114. HPR I Programs' Use of Data: Phase II Respondents
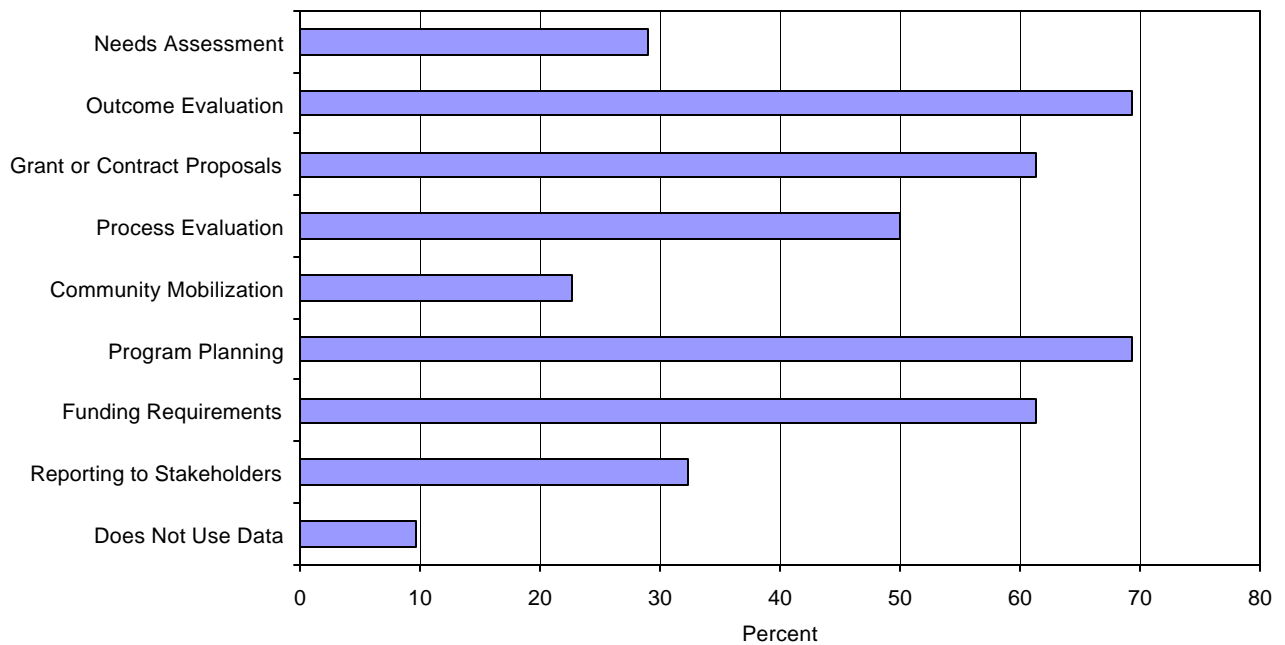
Exhibit 3-115 presents the findings for HPR II. The majority of respondents (94%) in HPR II also reported using data for at least one purpose. More than 50 percent of respondents reported using data for the following purposes:

- Program planning (84.9%);

- Outcome evaluation (71.2%);

- Grant or contract proposals (69.9%);

- Funding requirements (63.0%);

- Process evaluation (68.5%); and

- Reporting to stakeholders (54.3%).

Exhibit 3-115. HPR II Programs' Use of Data: Phase II Respondents
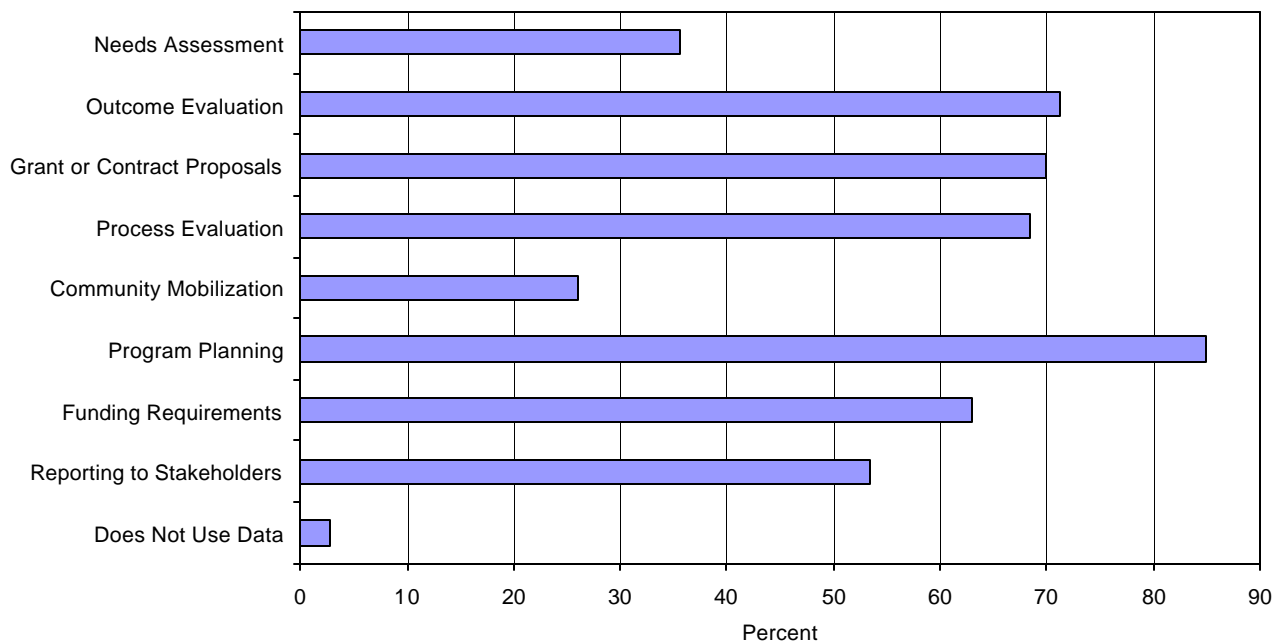
Exhibit 3-116 presents the findings for HPR III. Similarly, in HPR III the majority of respondents reported using the data for at least one purpose (92%). More than 50 percent of respondents reported using data for the following purposes:

- Program planning (75.0%);
- Grant or contract proposals (75.0%);
- Outcome evaluation (72.2%);
- Funding requirements (59.7%);
- Process evaluation (59.7%); and
- Reporting to stakeholders (50.0%).

Exhibit 3-116. HPR III Programs' Use of Data: Phase II Respondents
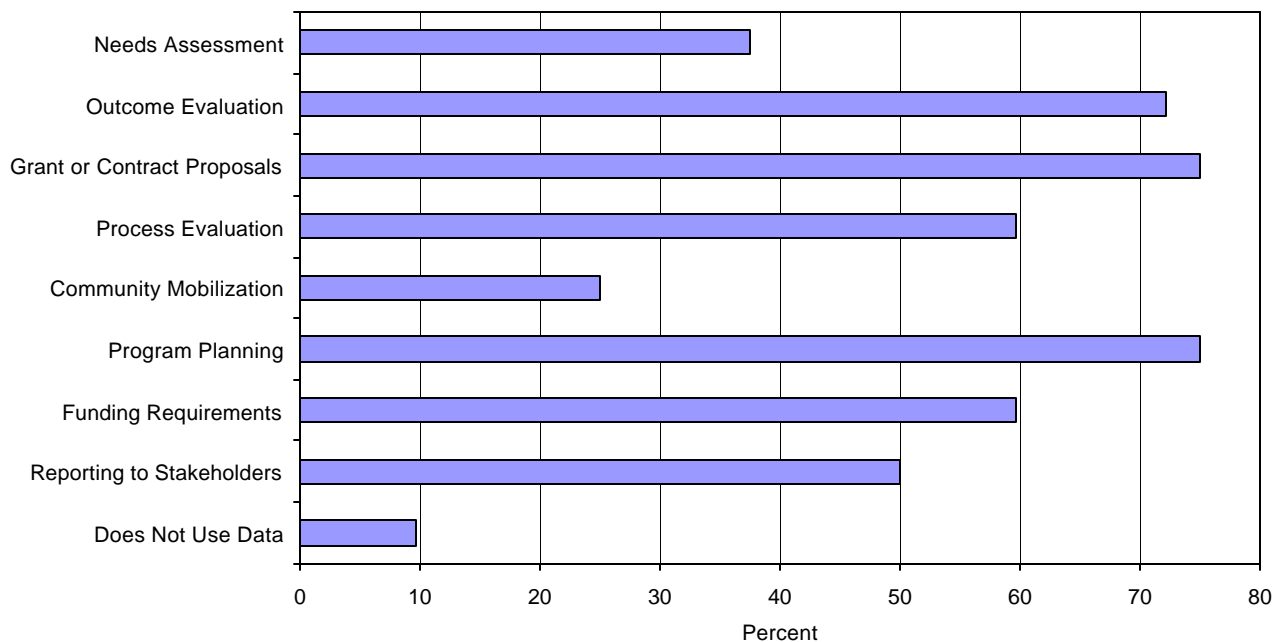
Exhibit 3-117 presents the findings for HPR IV. Ninety-five percent of respondents in HPR IV reported using data for at least one purpose. More than 50 percent of respondents reported using data for the following reasons:

- Grant or contract proposals (86.2%);

- Program planning (74.1%);

- Funding requirements (69.0%);

- Outcome evaluation (63.8%);

- Process evaluation (55.2%); and

- Reporting to stakeholders (50.0%).

Exhibit 3-117. HPR IV Programs' Use of Data: Phase II Respondents
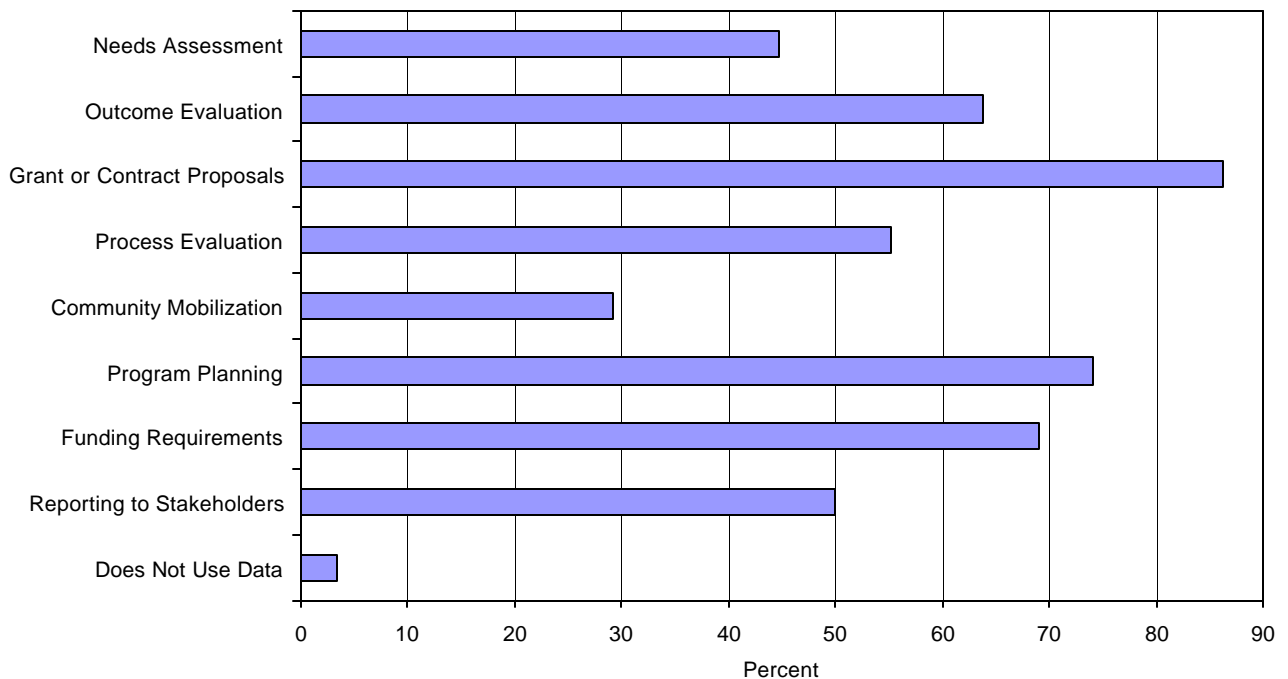
Exhibit 3-118 presents the findings for HPR V. Ninety-six percent of respondents in HPR V reported using data for at least one purpose. More than 50 percent of respondents in HPR V reported using data for the following reasons:

- Program planning (83.3%);

- Grant or contract proposals (80.3%);

- Outcome evaluation (68.2%);

- Process evaluation (68.2%); and

- Funding requirements (62.1%).

Exhibit 3-118. HPR V Programs' Use of Data: Phase II Respondents
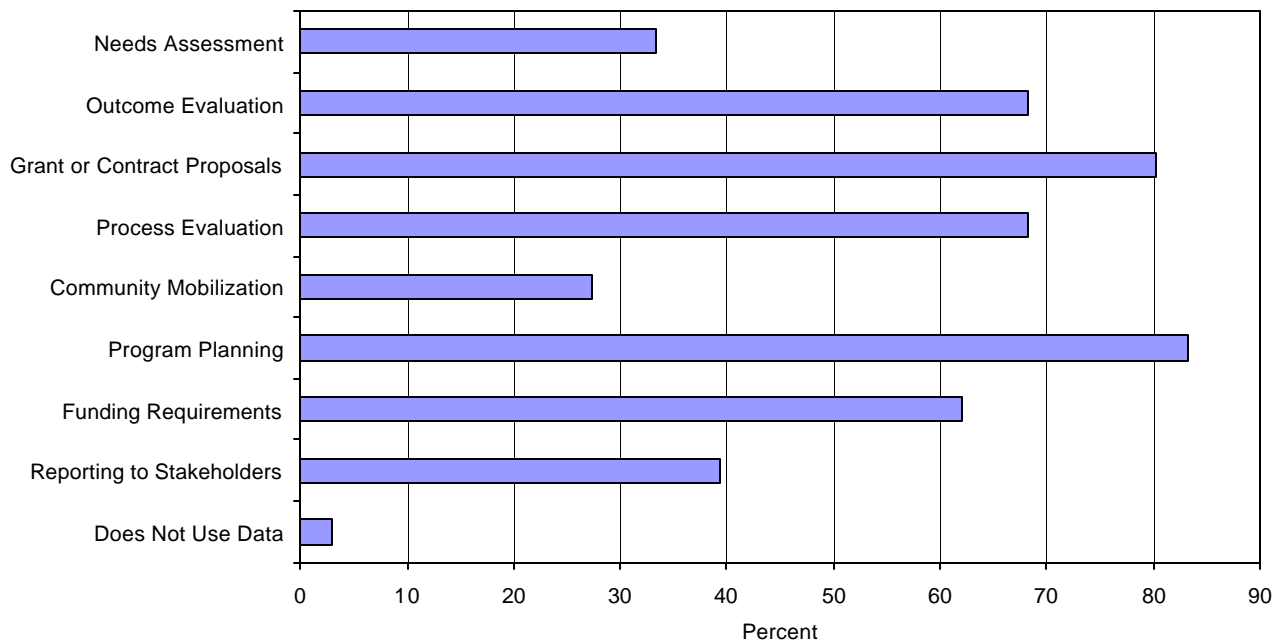
3.2.8.2   *Evaluation*

To collect information on program evaluation, respondents were asked if they conducted process or outcome evaluations and, if so, who conducted the evaluation.

In the Commonwealth, the majority of respondents reported that they conducted either a process or outcome evaluation. Only 12.56 percent of respondents reported that they did not conduct any evaluation. Similar findings were found across the five HPRs. A relatively small number of respondents reported that they did not conduct any evaluation, excluding HPR III, in HPRs I (16.7%), HPR II (7.0%), HPR IV (7.3%), and HPR V (8.1%). However, more than 20 percent of participants in HPR III reported that they did not conduct any program evaluations.

Exhibit 3-119 presents the findings on the responsible party for the collection of evaluation data. Of those respondents who collected data for program or outcome evaluations in the Commonwealth, the majority (82.0%) of the evaluations were conducted by in-house staff, 11 percent were contracted out and 7 percent were both conducted by in-house staff and contracted out.

Similar findings were observed across all five HPRs. In-house staff conducted the majority of evaluations. Of those respondents who reported conducting program evaluations, the majority of the evaluations in HPRs I (82.0%), II (85.0%), III (85.0%), IV (82.0%), and V (81.0%) were conducted by in-house staff. A relatively small percentage of respondents reported contracting out for evaluations in HPRs I (10%), II (7.5%), III (11%), IV (12%), and V (11%).

Exhibit 3-119. Individuals Responsible for Program Evaluation:
Phase II Respondents
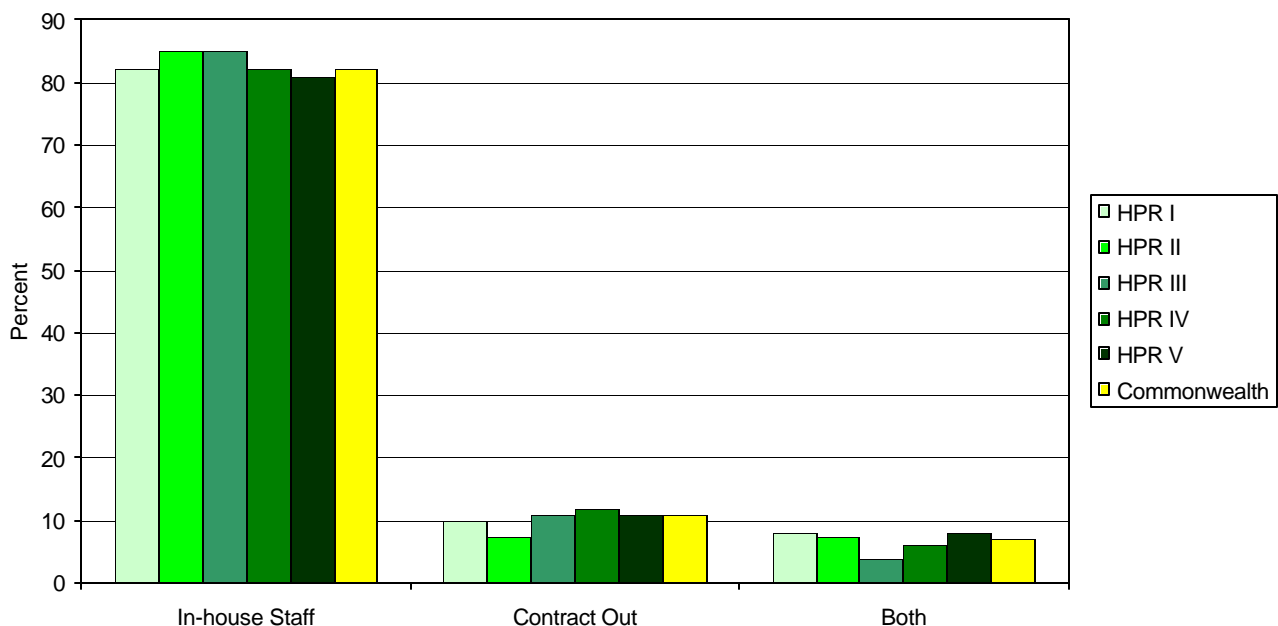
Exhibit 3-120 presents the findings on when evaluation data were collected. Respondents indicated the most common times data were collected for evaluations were during the program (57.7%) and immediately following the end of the program (43.0%). Approximately 30 percent of respondents collected data at the beginning of the program. Less than 15 percent (13.4%) of respondents reported that they collected long-term followup data (i.e., months or years after the program ended).

Similarly, the most common time of data collection in HPRs I (49.1%), II (62.3%), III (63.2%), IV (51.9%), and V (57.6%) was during the program. The second most common time of data collection across all five HPRs was immediately following the end of the program (HPRs I (45.6%), II (34.8%), III (54.4%), IV (42.6%), and V (47.5%).

Exhibit 3-120. Time Evaluation Data Collected: Phase II Respondents
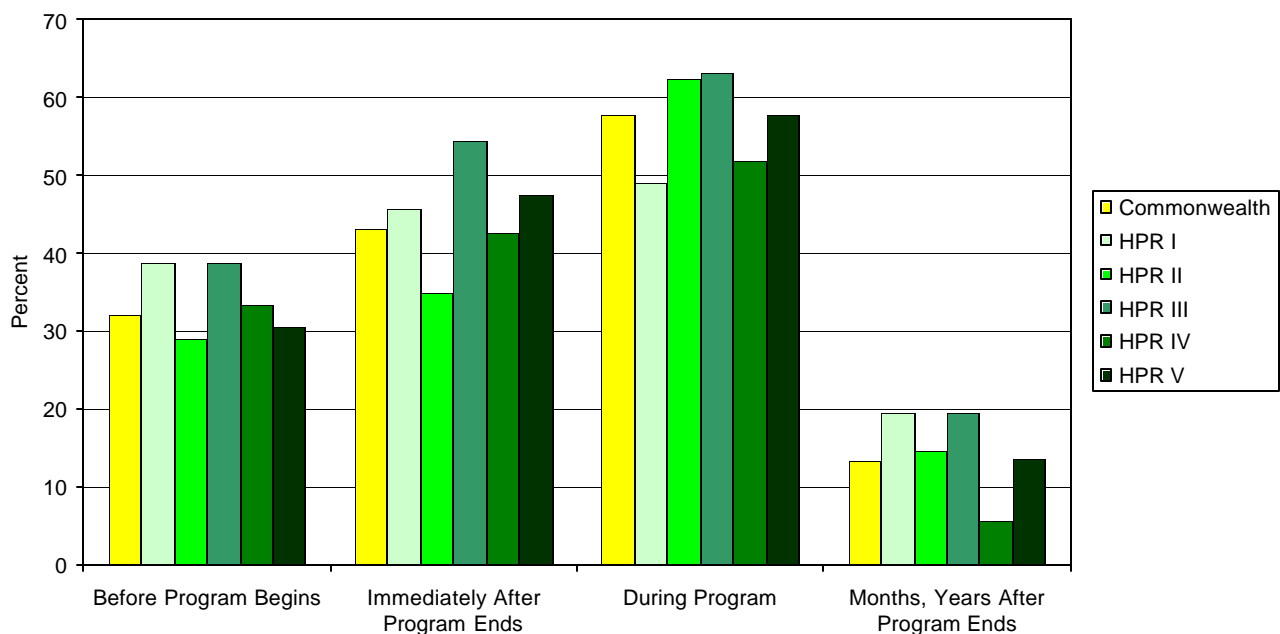
3.2.9 *Program Collaboration*

Exhibit 3-121 presents the findings on collaborative efforts of respondents. The majority of respondents in the Commonwealth (87.3%) reported that they cosponsor events with other community agencies somewhat or a lot. In addition, 92.9 percent of respondents indicated that they engage in joint planning with other community agencies somewhat or a lot. A smaller but relatively large percentage (50.5%) of respondents indicated that they shared funding or staff with other community agencies somewhat or a lot.

Similarly, the majority of respondents across all five HPRs reported collaborating with other community agencies somewhat or a lot on cosponsoring events and joint planning. Approximately half of all respondents reported sharing funding or staff with other community agencies somewhat or a lot across all five HPRs.

Exhibit 3-121. Collaboration with Other Community Agencies: Phase II Respondents
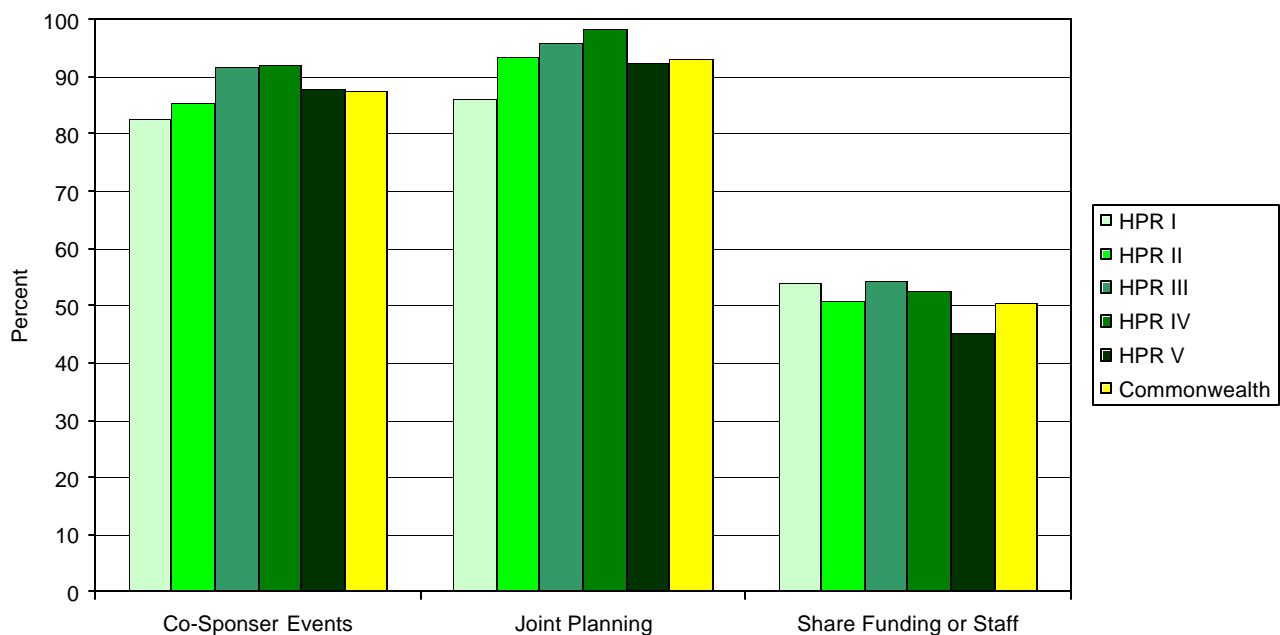
3.2.10   *Program Barriers*

Exhibit 3-122 presents the findings for reported barriers to service delivery in the Commonwealth. Surprisingly, a relatively small number of respondents reported significant barriers to service delivery. Indeed, only insufficient staff (37.2%) was reported to be a significant barrier by more than 20 percent of respondents. More than 50 percent of respondents in the Commonwealth reported that lack of public awareness (62.1%) and participant drop-out (53.2%) were minor-to-moderate barriers.

More than half of all respondents indicated that the following were **not** barriers to service delivery:

- Program location is unsafe (90.1%);

- Service fee is not affordable (77.6%);

- Lack of childcare facilities (67.8%);

- Program eligibility criteria too restrictive (64.3%);

- Waiting lists (63.0%);

- Insufficient collaboration with schools (55.8%); and

- Insufficient collaboration with community organizations (54.4%).

Exhibit 3-122. Commonwealth Barriers to Service Delivery: Phase II Respondents
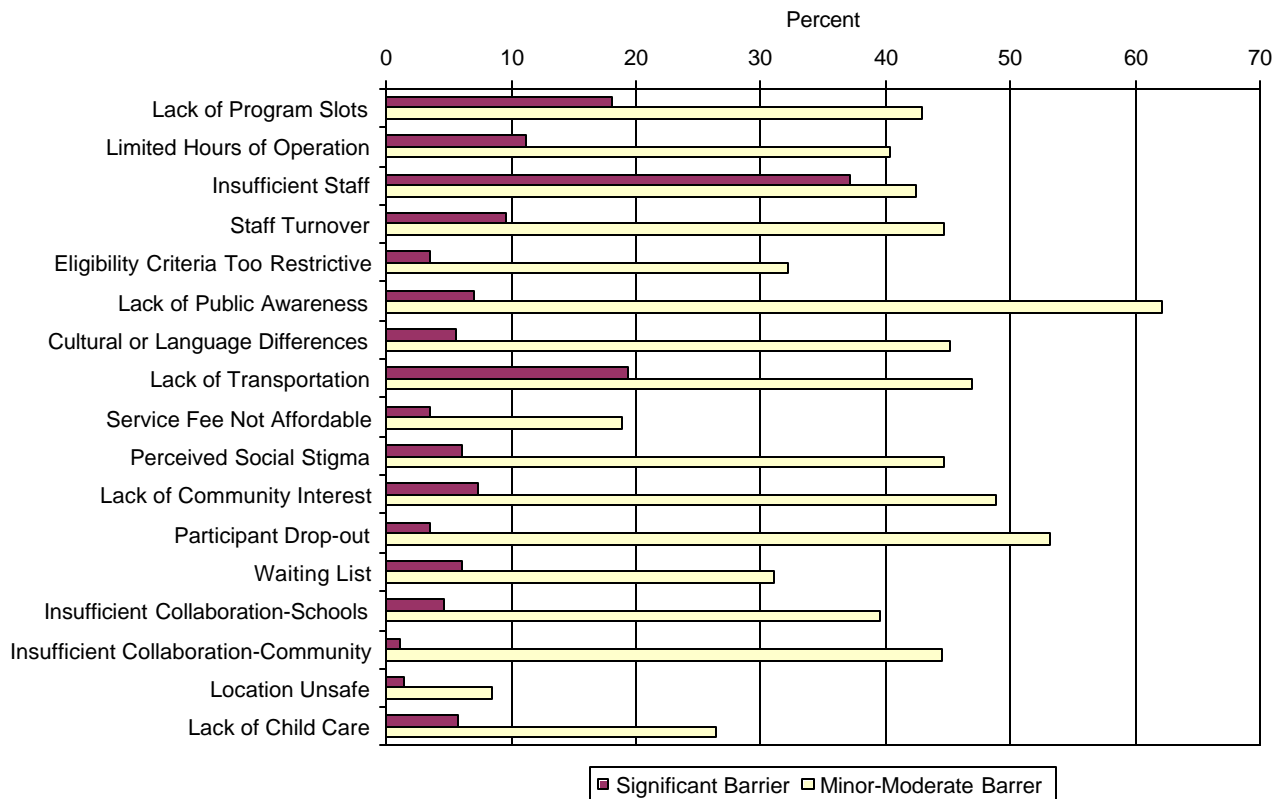
The most common barrier reported to be significant across all five HPRs was insufficient staff due to lack of funding. However, respondents' perceptions of other types of barriers to service delivery varied by HPR.

Exhibit 3-123 presents the findings for reported barriers to service delivery in HPR I. In HPR I, only insufficient staff due to lack of funding (35.2%) was reported to be a significant barrier by over 20 percent of respondents. More than 50 percent of respondents reported that lack of public awareness (54.8%), cultural or language differences (57.4%), and lack of transportation (52.7%) were minor-to-moderate barriers to service delivery in HPR I. More than 50 percent of respondents reported that the following were **not** barriers to service delivery:

- Program location is unsafe (94.3%);

- Service fee is not affordable (84.9%);

- Lack of childcare facilities (64.8%);

- Program eligibility criteria is too restrictive (64.2%);

- Insufficient collaboration with schools (60.4%);

- Waiting lists (57.7%);

- Insufficient collaboration with community organizations (56.6%); and

- Staff turnover (51.9%).

Exhibit 3-123. HPR I Barriers to Service Delivery: Phase II Respondents
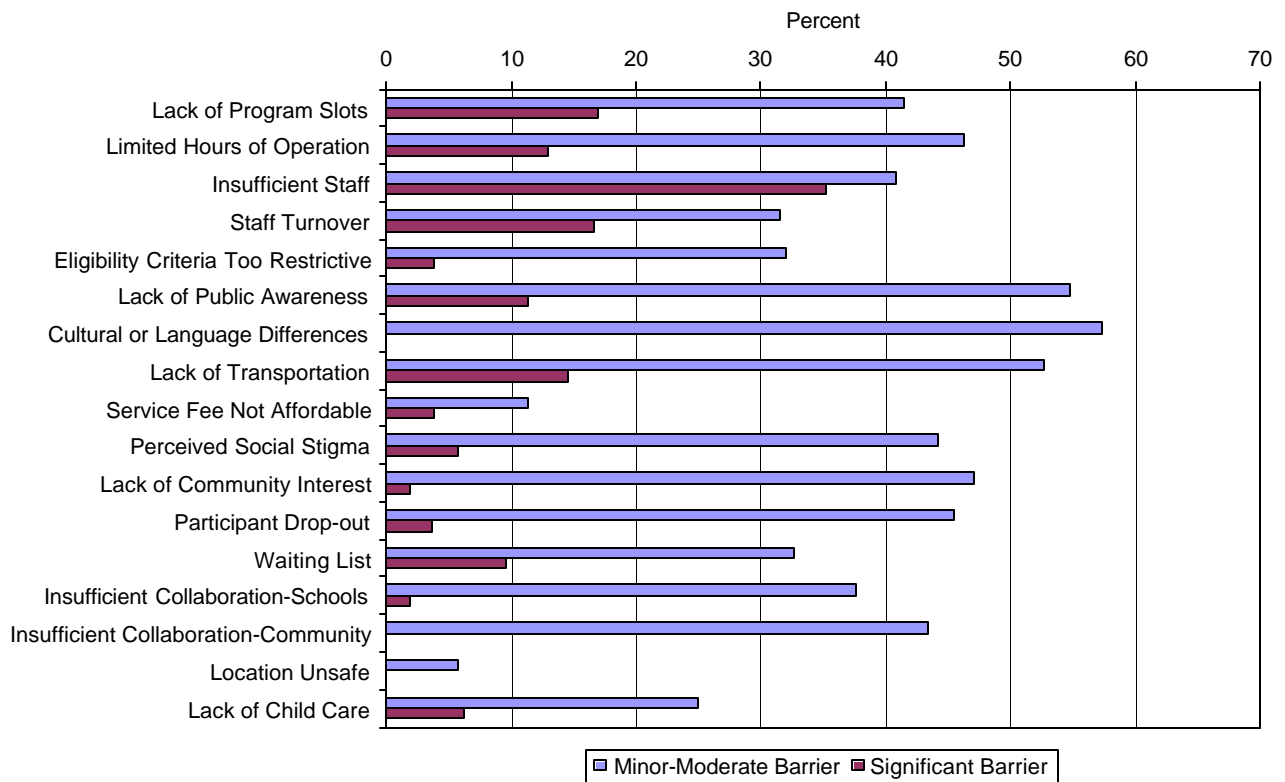
Exhibit 3-124 presents the findings for reported barriers to service delivery in the HPR II. In HPR II, three of the 17 possible barriers were reported to be significant barriers by more than 20 percent of respondents, including:

- Insufficient staff due to lack of funding (44.4%);
- Lack of transportation to and from services (24.6%); and
- Lack of available program slots (23.0%).

More than 50 percent of respondents reported that the following are minor or moderate barriers to service delivery in HPR II:

- Cultural or language differences (69.3%);
- Lack of public awareness (58.7%);
- Staff turnover (56.5%);
- Lack of program slots (52.4%); and
- Participant drop-out (50.8).

Exhibit 3-124. HPR II Barriers to Service Delivery: Phase II Respondents
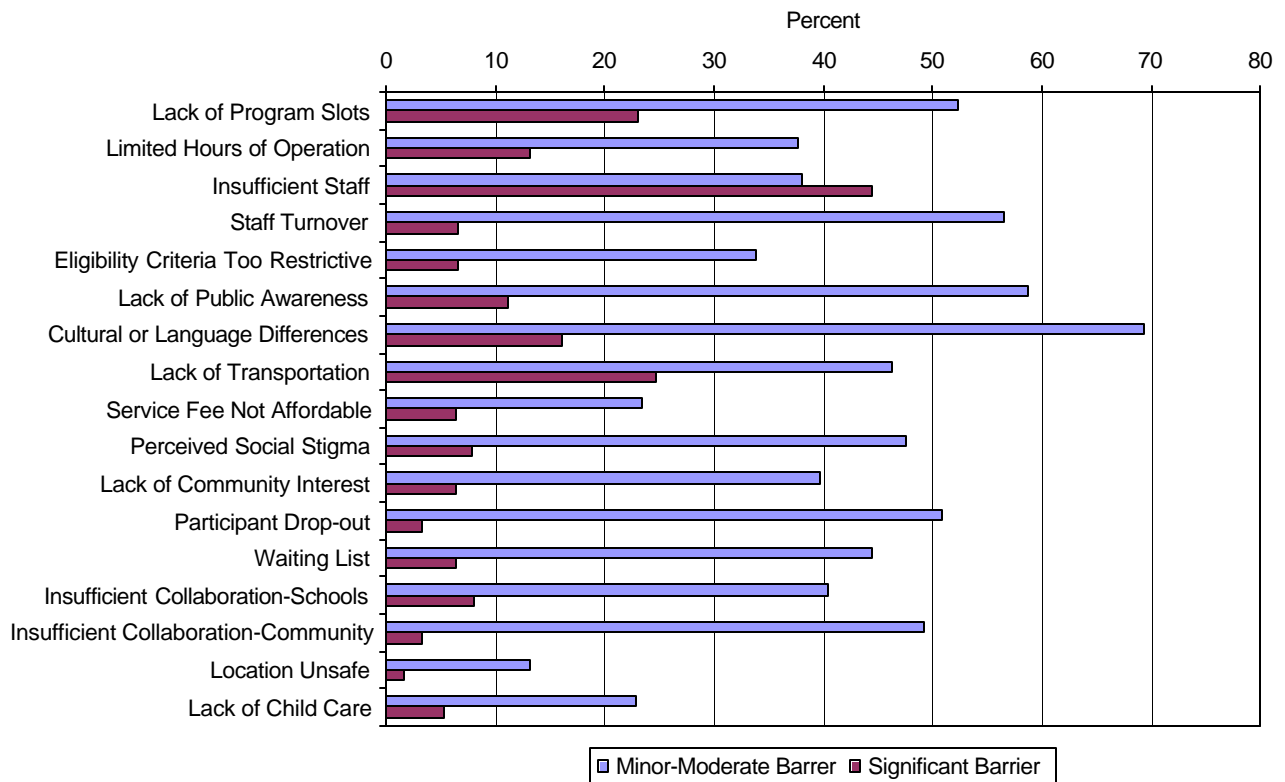
Exhibit 3-125 presents the findings for reported barriers to service delivery in the HPR III. In HPR III, only two of the 17 possible barriers were reported to be significant by more than 20 percent of respondents: insufficient staff due to lack of funding (27.9%) and lack of available program slots (24.6%). More than 50 percent of respondents reported that lack of public awareness (69.5%) and participant drop-out (53%) were minor-to-moderate barriers to service delivery in HPR III. More than 50 percent of respondents reported that the following are not barriers to service delivery:

- Program location is unsafe (92.8%);

- Service fee is not affordable (85.5%);

- Cultural or language differences (72.1%);

- Lack of childcare facilities (68.8%);

- Waiting lists (65.7%);

- Eligibility criteria is too restrictive (62.9%);

- Staff turnover (57.4%).

- Insufficient collaboration with community organizations (56.5%);

- Insufficient collaboration with schools (51.5%); and

- Limited hours of operation (50.7%).

Exhibit 3-125. HPR III Barriers to Service Delivery: Phase II Respondents
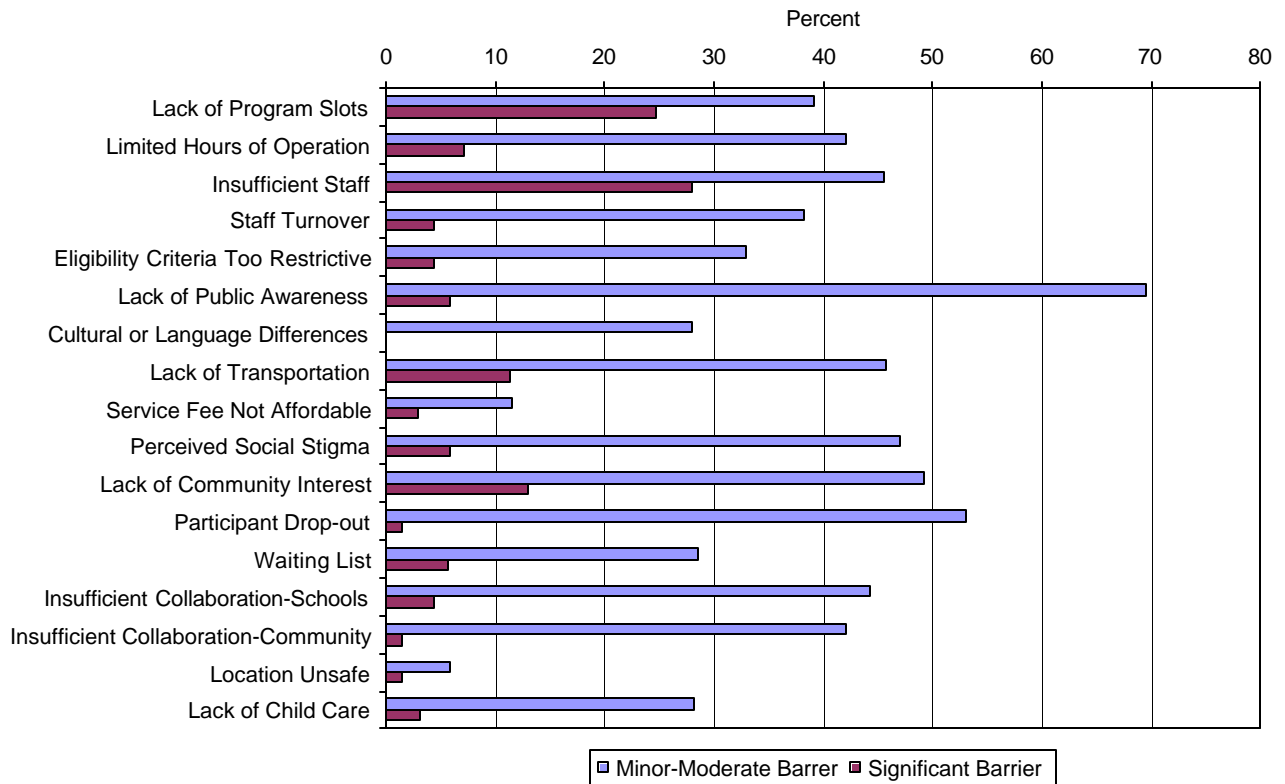
Exhibit 3-126 presents the findings for reported barriers to service delivery in HPR IV. In HPR IV, insufficient staff due to lack of funding (36.4%) and lack of transportation to and from services (31.0%) were perceived as significant barriers to service delivery by more than 20 percent of respondents. More than 50 percent of respondents reported that lack of public awareness (70.3%), lack of community interest (58.9%), and participant drop-out (62.9%) were minor-to-moderate barriers to service delivery in HPR IV. More than 50 percent of respondents reported that the following were **not** barriers to service delivery:

- Program location is unsafe (90.4%);

- Service fee is not affordable (70.4%);

- Waiting lists (68.5%);

- Eligibility criteria is too restrictive (59.3%);

- Insufficient collaboration with schools (52.8%);

- Lack of childcare facilities (53.1%); and

- Insufficient collaboration with community organizations (51.9%).

Exhibit 3-126. HPR IV Barriers to Service Delivery: Phase II Respondents
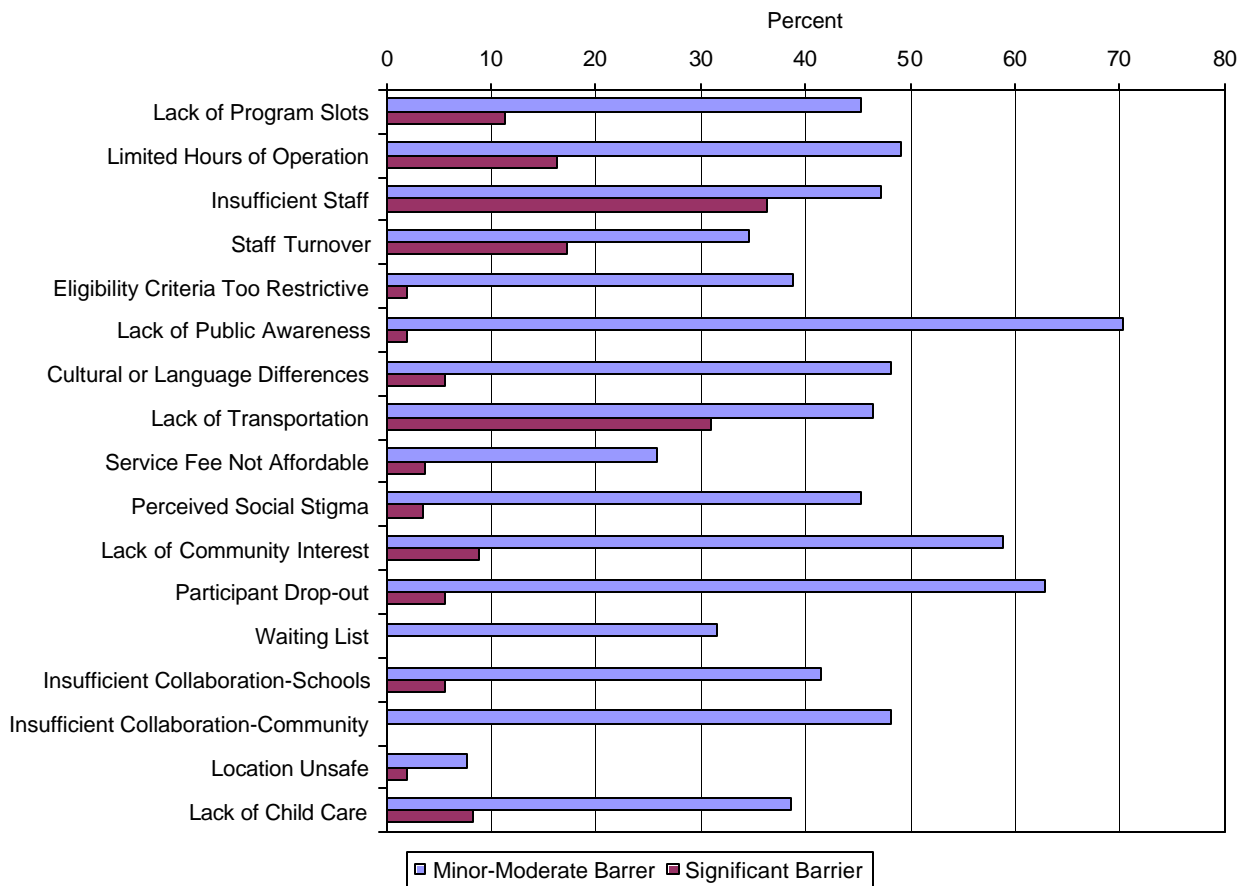
Exhibit 3-127 presents the findings for reported barriers to service delivery in HPR V. In HPR V, only one of the 17 possible barriers was perceived as significant by more than 20 percent of respondents: insufficient staff due to lack of funding (44.8%). More than 50 percent of respondents reported that staff turnover (54.4%) and lack of public awareness (60.8%) were minor-to-moderate barriers to service delivery in HPR V. More than 50 percent of respondents reported that the following were **not** barriers to service delivery:

- Program location is unsafe (86%);

- Service fee is not affordable (78.6%);

- Lack of childcare facilities (70.6%);

- Waiting lists (69.6%);

- Eligibility criteria is too restrictive (67.3%);

- Cultural or language differences (62.5%);

- Limited hours of operation (60.7%);

- Insufficient collaboration with schools (57.9%);

- Insufficient collaboration with community organizations (55.4%);

- Perceived social stigma (53.6%); and

- Lack of community interest (53.6%).

Exhibit 3-127. HPR V Barriers to Service Delivery: Phase II Respondents
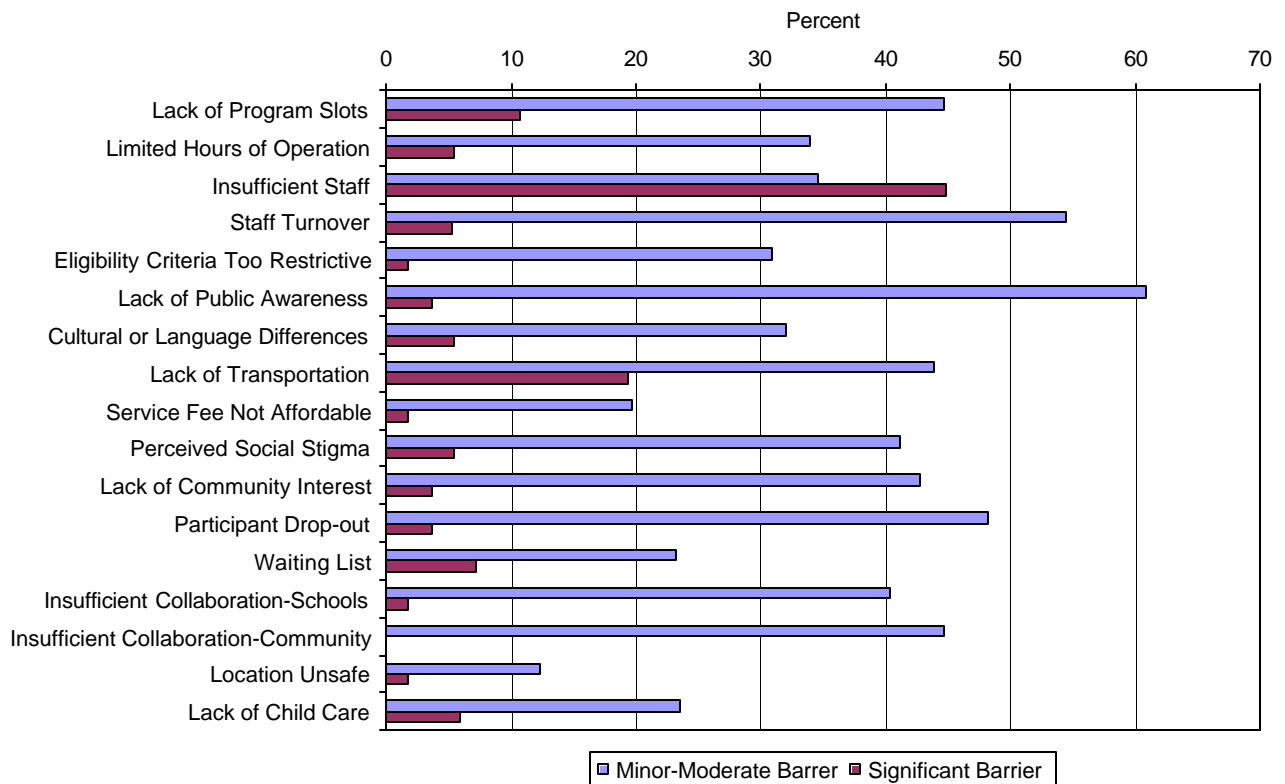
4. SUMMARY OF FINDINGS AND IMPLICATIONS FOR PREVENTION PLANNING

The results of the Community Resource Assessment can be used in the prevention planning process for the Commonwealth of Virginia and can provide planners with current and accurate information regarding local prevention resources that target problem behaviors through the reduction of risk factors and the promotion of protective factors. The integrated results of the Community Resource Assessment, the Community Youth Survey, and the Social Indicators Study will provide State and sub-State planners with information concerning the match between available ATOD-related resources and ATOD-related needs. Prevention planners may use the integrated results to allocate resources to fill gaps in services, in order to more effectively reduce salient risk factors and enhance protective factors.

While the current findings from the Community Resource Assessment Survey can be invaluable to prevention planners, the fact that the Community Resource Assessment study was a pilot study, including the Phase I and Phase II surveys, must be taken into account. The findings from the present study should be used with caution for a number of reasons. First, surveys for Phase II of the study were only administered in a select few localities (10 CSB geographic regions). The generalizability of these results to the HPR level is limited at best. To provide planners with information at the HPR level, resource assessment surveys should be administered to programs operating in all localities within an HPR.

A second limitation of the current study is the response rate: only half of potential Phase II participants completed and returned surveys. The large scope of the study may have contributed to the low response rate. We attempted to collect detailed information from all existing prevention programs targeting risk and protective factors within a specified locality. These included private as well as publicly funded programs. There may have been little perceived incentive for non-State affiliated private programs to respond to this VADMHMRSAS administered survey. It is suggested that future efforts involve collaboration with local coalitions in order to increase the response rate. Local coalitions may have more influence encouraging a wide range of program directors to complete the surveys.

The third limitation of the current study is the pilot nature of the Community Resource Assessment surveys. The surveys, designed by a CSAP workgroup, were not tested in the field prior to the implementation of this study. Revisions to the Phase I and Phase II instruments may be warranted in order to produce a more useful and valuable survey for prevention planning. While a number of the survey questions could be valuable for other purposes, a large number of questions are not necessary for identifying available resources that target risk and protective factors in order to assess the match between those resources and identified needs. Future efforts may focus on reducing the number of questions in the survey instrument, which, in turn, may increase the response rate.

The purpose of a community resource assessment, as part of a needs assessment, is to collect information on available prevention resources to assess the match between those resources and identified needs. As discussed in Chapter 1, prevention planning may follow a basic public health problem-response approach that includes (1) defining the problem, (2) identifying risk and protective factors, (3) identifying and implementing interventions, and (4) conducting program evaluations. Step Three of this process involves identifying available resources that can be used to address the problem (defined in Step One) through the reduction of salient risk factors and the enhancement of salient protective factors (identified in Step Two). Information collected through the Community Resource Assessment should focus on identifying resources that can be used for Step Three: information that identifies available resources that can or are targeting salient risk factors and enhancing protective factors.

The following section summarizes relevant findings from the Community Resource Assessment, discusses the limitations of the Community Resource Assessment survey, and describes the usefulness of the findings in the prevention planning process.

4.1   Summary of Relevant Findings

This section will provide a summary of the findings relevant for Step Three of the planning process. Only findings from the surveys that are believed to be relevant for Step Three are discussed. These include goals and objectives, services provided, budget, and training and TA provided to the field.

4.1.1   *Goals and Objectives—Open-Ended*

Not surprisingly, different responses to the open-ended question regarding main program goals and objectives were observed for Phase I and Phase II respondents. Responses from Phase I respondents were global and focused on increasing the effectiveness and efficiency of prevention programs across the state, whereas responses obtained from Phase II respondents were more program-focused.

4.1.1.1   *Phase I*

The three goals and objectives most commonly reported by Phase I respondents were (1) *building effective prevention programs*; (2) *meeting the needs of localities*; and (3) *preventing ATOD use.*

4.1.1.2   *Phase II*

Phase II respondent answers to the open-ended question regarding program goals and objectives indicated that the three most common goals and objectives of local programs in the Commonwealth were (1) *providing life skills/social skills training*; (2) *providing positive alternative activities*; and (3) *providing family management/skills training.* Similar findings were

observed across the five HPRs with one exception. In HPR II, *family self-sufficiency* was one of the three most common goals reported and providing alternative activities was not one of the three most common goals.

4.1.2 *Goals and Objectives-Close-Ended*

Throughout the Commonwealth, the most commonly reported goals and objectives, by far, fell within the individual domain. Phase II respondents were more likely to report that program objectives were youth-focused.

4.1.2.1 *Individual Domain*

Based on the findings from the close-ended question regarding main program goals and objectives in the individual domain, the three most common prevention program goals and objectives in the Commonwealth were *improving life/social skills, strengthening attitudes against antisocial behavior*, and *preventing antisocial behavior*. Across all five HPRs, the most commonly endorsed goal and objective was *improving life/social skills*. In addition, *strengthening attitudes against antisocial behavior* was one of the three most commonly reported program goals and objectives across all five HPRs. In HPR I, *strengthening perceptions about the negative effects of ATOD use* was also one of the three most commonly reported goals and objectives. In HPRs II, III, and V, *preventing ant-social behavior* was a common goal and objective. In HPR IV, *strengthening attitudes against ATOD use* was a commonly reported goal and objective.

4.1.2.2 *Family Domain*

Based on the findings from the close-ended question regarding main program goals and objectives in the family domain, the two most common objectives in the Commonwealth were *improving family communication skills* and *improving family management skills*.

In HPRs I, III, IV, and V one of the two most common goals and objectives was *improving family management skills*. In HPRs III, IV, and V one of the two most common goals and objectives in the Family Domain was *improving family communication skills*. In addition, in HPRs I and II, *improving parents' ability for pro-social family involvement* was the most common objective reported. In HPR II, the second most common goal or objective was *increasing parents' ability to reward positive family involvement*.

4.1.2.3 *School Domain*

A smaller percentage of respondents reported that their program goals and objective fell within the school domain across the Commonwealth, excluding HPR IV. The two most commonly reported program goals and objectives in the Commonwealth were *increasing opportunities for pro-social involvement in the school* and *increasing school commitment*. Similar findings were observed across all five HPRs. In HPRs I, II, III, IV, and V, *increasing*

opportunities for pro-social involvement in the schools and *school commitment* were the two most commonly reported goals and objectives.

4.1.2.4   *Community Domain*

In the Commonwealth, the two most commonly reported goals and objectives in the community domain were increasing positive opportunities for pro-social involvement in the community and improving neighborhood safety, organization and/or a sense of community. Similar findings were found across the five HPRs. In HPRs I, II, III, IV, and V, one of the two most commonly reported goal and objective was increasing opportunities for pro-social involvement in the community. In HPRs III, IV, and V, improving neighborhood safety, organization and/or a sense of community was one of the two most commonly reported goals and objectives. In HPR I, strengthening community norms/attitudes against ATOD use was one of two most commonly reported goals and objectives. In HPR II, increasing rewards for positive community involvement was the second most commonly reported objective.

Interestingly, whereas one of the most common needs reported by Phase II respondents across the Commonwealth was *substance use prevention*, *preventing* or *delaying ATOD use* was not a common goal or objective.

4.1.3   *Services Provided*

Respondents reported the types of services provided by their programs within the four life domains: individual, family, school, and community.

4.1.3.1   *Individual Domain*

The most common services reported by Phase I respondents in the individual domain were Life/Social Skills Training, Drug-Free Social Activities, and Mentoring Services.

Similarly, the most common services reported by Phase II respondents in the Commonwealth were Life/Social Skills Training, Mentoring, and Youth Community Services. Similar findings were observed in all five HPRs.

4.1.3.2   *Family Domain*

The most common services reported by Phase I respondents in the family domain were Parenting/Family Management Training and Prenatal/Infancy Services. The most common services reported by Phase II respondents in the family domain were Parenting/Family Management Training and Family Support. Similar findings were observed across all five HPRs.

4.1.3.3   *School Domain*

The most common services reported by Phase I respondents in the school domain were related to Organizational Change In The Schools and School Behavior Management. The most common services reported by Phase II respondents in the school domain were Organizational Change in the Schools and Classroom Organization, Management and Instructional Practices. Similarly, Organizational Change was the most commonly reported service by Phase II respondents in all five HPRs. In HPRs I, III, and V the Enforcement of School Policies That Discourage Substance Use was also a commonly reported service in the school domain. In HPRs II and III, Behavior Management was a commonly reported service. In HPR IV, Classroom Organization, Management, and Instruction Services were the second most common service reported by Phase II respondents.

4.1.3.4   *Community Domain*

The most common services reported by Phase I respondents in the community domain were Information Dissemination, Community Mobilization, and Media Campaigns.

Similarly, Phase II respondents also reported that Information Dissemination, Community Mobilization, and Media Campaigns were the most common services provided in the Commonwealth. Across all five HPRs, Information Dissemination was one of the most common services provided in the community domain. In HPRs I, III, and IV, Media Campaigns were also a common service reported by Phase I respondents. In HPRs II and V, Community Mobilization was the second most common service reported by Phase II respondents.

4.1.4   *Budget*

The average annual budget for prevention programs at the State level in the Commonwealth was $10,010,128. Annual budgets reported by Phase I respondents ranged from $10,000 to $64,000,000. The average reported budget for prevention programs in the Commonwealth, reported by Phase II respondents, was $535,851, with a range of $1,000 to $18,000,000. HPR II reported the highest average annual budget at $1,176,575, with a range of $1,500 to $18,000,000. HPR V had an average annual budget of $393,850, with a range of $3,000 to $2,850,000. The lowest reported annual budget was in HPR I at $182,757, with a range of $1,000 to $2,251,510. The average annual budget in HPR III was $388,497, with a range of $5,000 to $4,754,281. In HPR IV, the average annual reported budget was $460,032, with a range of $4,000 to $5,000,000.[*]

---

[*] Annual budget information was provided by survey respondents. The respondents may not have been program administrators with day-to-day knowledge of program budgets. In some cases where unusually large budgets were reported (e.g., 18,000,000), the prevention programs were part of large multiservice county agencies, and respondents may have been reporting larger agency-wide budgets.

4.1.5   *Training and TA Provided to the Field*

The most common training provided to the field, as reported by Phase I respondents, was Training Specific To Each Particular Program (i.e., daycare providers may receive training on State code for daycare centers, information on how to care for children, etc.). The second most common training provided to the field was on Program Management and Development. Phase I respondents also reported that they provided Training on Grant Writing and Funding Opportunities, the third most common training.

4.2   Survey Limitations

The following section discusses the limitations of the Phase I and II surveys instruments and methods for streamlining them. The relevance of survey questions for the purposes of a needs assessment is discussed.

4.2.1   *Length of Survey*

One of the main concerns raised by Phase II respondents was that the survey instrument was too long. Indeed, the Phase II survey is 8 pages long with 171 questions. The length of the survey may also explain the lower-than-anticipated response rate. Service providers have many responsibilities and limited resources. Thus, many of the respondents may have simply not had the time available to respond to the survey. Based on this assessment, a priority for future resource assessments may be to significantly reduce the number of survey questions. In addition, as previously stated, a number of survey questions, while valuable, may not be relevant for a resource assessment.

4.2.2   *Perceived Need*

Information on **perceived** needs may be interesting, but should not be included as part of the resource assessment. Even as part of the overall needs assessment, defining the needs of localities based on subjective assessments by service providers is not a preferred strategy. This strategy can be extremely biased and based on observations that are constrained by the individual's job. For example, individuals working for social service agencies may be more likely to define child abuse as a problem, whereas staff from local health departments may be more likely to define teen pregnancy as a problem. The questions regarding perceived needs are unessential for the Community Resource Assessment and should be discarded from both the Phase I and Phase II survey instruments.

4.2.3   *Services Provided*

The services provided by prevention programs can be helpful in identifying strategies used by prevention programs to meet their goals and objectives. It is also useful for questions regarding services to be categorized into the four life domains—thus, easily tying services to needs identified through archival

indicators and youth surveys. These questions about services provided within each domain should be maintained in the Community Resource Assessment instrument.

However, one question regarding services asked respondents to select one service that best described their program. The majority of respondents were unable to provide this information because their programs engaged in multiple strategies to meet goals and objectives. Indeed, CSAP recommends the use of multiple strategies to meet goals and objectives. This question focusing on one service is confusing as well as uninformative and should be discarded.

4.2.4   *Program Intensity*

The Phase II survey collected information on the number of weeks programs operated, the average length of programs, and the number of times each session took place within a weeklong period. This information was designed to provide data on program intensity or "dosage." Research has shown that program intensity, in part, is linearly related to program effectiveness (i.e., the stronger intensity, the more effective the program). While this information may be important, one may want to consider discarding these questions for two reasons.

First, the results of the questions can be misleading. For example, respondents who worked in health clinics often reported that their programs operated 52 weeks of the year, 7 days a week. Based on this information, a conclusion may be made that these types of services are the most intense and, thus, likely the most effective. However, while the clinics may be open 52 weeks, 7 days a week, individual clients are not receiving services for this specific length of time. Indeed, clients attending the health clinic may not receive any prevention-related services.

Second, information on program intensity is not directly relevant to the goals of the needs assessment and, therefore, may be considered superfluous. Instead, questions regarding whether or not the program is research-based would provide more informative data on program effectiveness.

4.2.5   *Primary Populations Served*

The Phase II survey collected information on the primary populations served by local programs. Data on primary populations can be used to determine what types of populations local programs are serving. This information can be used to determine whether programs are targeting populations with identified needs. For example, if family conflict is identified as a salient risk factor in Step Two, then resources should target parents and families. Information on primary populations will allow planners to assess what populations are being targeted in a given locality. Therefore, these questions should remain in the Community Resource Assessment instrument.

4.2.6   *Population Demographics*

A number of questions on the Phase II survey collected information on the demographics of program participants. While this information may be useful for a process evaluation, it will only be helpful to a locality in evaluating the match between identified needs for specific target populations and populations served by available resources. Demographic information may be discarded from the Community Resource Assessment if a locality has not identified needs for specific target populations.

4.2.7   *Staffing*

Phase I and Phase II surveys collected information on the number of prevention staff employed by surveyed programs. In addition, the Phase II survey collected information on the number of hours worked by staff, including part-time and volunteers. The Phase I survey also collected information on the number of staff working in the entire agency and the number of staff devoted to prevention. The purpose of these questions was twofold. One purpose was to gather information on available human resources. Human resources themselves can be considered a prevention resource. However, this information by itself is not necessarily useful and is really only helpful if used in conjunction with information regarding the job duties of staff (i.e., how many of the staff provide direct services) and the needs of the program. For instance, are five full-time staff needed to effectively provide services and only three are available. In the end, even this type of information may not be useful for Step Three: identifying resources that are available to target identified need. Staffing is typically a function of budget and may be redundant if both sets are questions are used.

The second purpose of the staffing questions was to gather information on the percentage of prevention staff compared to other treatment staff. However, this information is not relevant for purposes of the needs assessment. Documenting that there are less prevention dollars than treatment dollars does not help identify resources that are available for targeting risk factors. Therefore, staffing questions may be discarded from the survey if budget questions are retained.

4.2.8   *Budget*

Information on funding streams can be helpful for identifying resources available for prevention programming. However, budget information alone does not address this question. Budget information would be more informative if data were collected on where the funding comes from and how much each funding source provides. In the Phase I survey, attempts were made to collect this type of information, but the question regarding funding sources was too general and, therefore, not very useful. Questions that tap into the funding streams of prevention programs would be the most useful. Questions aimed at gathering information regarding the amount of money, funding sources (who, what, and how much), and how the money is spent (i.e.,

how much of the money is spent on direct service provision) should be added to the Community Resource Assessment instrument.

4.2.9   *Data and Evaluation*

A number of questions on both the Phase I and Phase II surveys attempted to gather information on data uses and program evaluation. Again, information that would be useful for Step Three is whether or not respondents collect needs assessment data. This information might be helpful for planners to avoid redundancy in primary data collection efforts. Otherwise, information on respondents' use of data or the types of data they collect is not relevant for a needs assessment and therefore should be discarded from the surveys. However, one question attempted to collect information on the types of data Phase I respondents reported to others. This question could be modified to collect information on data that is (or can be) provided to the State and local prevention service providers or planners to assist in their needs assessment efforts.

Data on program evaluation activities can be helpful for Step Four of the planning process. Step Four involves the evaluation of community prevention efforts based on identified need. This step can be accomplished, in part, through the evaluation of prevention programs. Efforts that are not effective should be modified or resources should be funneled elsewhere. However, the survey questions do not answer these questions. They only indicate whether or not programs were being evaluated. Knowing that the majority of respondents collect evaluation data at the beginning of the program and immediately following the end of the program does not provide information on the validity of the evaluation efforts. In addition, the current evaluation questions do not provide information on the findings from the evaluations: are the programs effective or not?

One important question, for the purposes of the needs assessment, is whether available programs are science-based. Questions concerning the nature of programming should be included in the survey instrument.

4.2.10   *Program Goals and Objectives*

The most important information collected in the surveys is the goals and objectives of prevention efforts. This information can be used directly to identify the types of resources available that target identified need. The questions on goals and objectives facilitated the collection of information on objectives regarding risk and protective factors within each of the four domains. This information is relevant and valuable for the purposes of any prevention needs assessment.

4.2.11   *Barriers*

Information on barriers to service delivery can assist prevention planners in identifying barriers to service delivery that should be addressed to increase the efficiency and effectiveness of prevention programming. However, this

information is not necessary to assess the availability of community resources. Information on barriers to service delivery cannot be utilized to assess the match between identified need and available resources and, therefore, these may be discarded from the survey instrument.

4.2.12   *Collaboration*

Coordination and sharing of prevention resources is an important method for enhancing available resources. Information collected during the survey on collaborative activities can assist prevention planners in making recommendations for efficiently matching resources to identified needs. Directors in the field that are not engaging in collaborative efforts may need training or encouragement to increase their collaborative activities. In addition, information on which groups/populations programs are collaborating with can be useful. For example, if a large percentage of programs are not collaborating with religious or civic organizations, training may be needed to provide local directors with methods to develop these relationships and tap into valuable prevention resources available in their community. While information on collaborative activities was collected in the Phase I survey instrument, it should also be added to the Phase II instrument.

4.2.13   *Training and TA Provided to the Field*

Training and technical assistance (T/TA) is a valuable resource available for prevention programming. Information on the types of T/TA provided can be informative for prevention planners and should continue to be included on both the Phase I and Phase II survey instruments.

4.3   Application in Prevention Planning

As previously discussed, approaches to ATOD prevention can be conceptualized as following a basic public health problem/response approach that includes (1) defining the problem, (2) identifying risk and protective factors, (3) identifying and implementing interventions, and (4) conducting program evaluations. Findings from the Virginia Community Resource Assessment can assist the Commonwealth and particularly local planning groups in Step Three of this process.

4.3.1   *Defining the Problem*

Findings from two other studies, the Virginia Community Youth Survey and the Virginia Social Indicator Study can be used to assist State and local planners in defining problem behaviors in the Commonwealth and across all five HPRs.

4.3.2   *Identifying Risk and Protective Factors*

Similarly, findings from the Virginia Community Youth Survey and the Virginia Social Indicator Study can be used in the second step of the prevention planning process to identify the risk factors known to increase the likelihood of ATOD problems and the protective factors that are known to buffer the influence of those risk factors.

4.3.3   *Identifying and Implementing Interventions*

The third step in the planning process involves identifying interventions (i.e., prevention programs that address the problems defined in Steps One and Two). This step involves the identification of available resources targeting the specific risk and protective factors identified in a particular region (i.e., HPR) in Step Two.

Findings from the Virginia Community Resource Assessment can identify available resources that target specific risk factors. For instance, based on the results of the Community Resource Assessment, we know that the main goals and objectives in the individual domain are the following:

- *Improving life/social skills*;
- *Strengthening attitudes against antisocial behavior*; and
- *Preventing antisocial behavior*.

These objectives are being met through the provision of life/social skills training, drug-free social activities, and mentoring services.

Assessing the match between objectives and services and identified need will allow prevention planners to determine if available resources are the most effective strategies in targeting identified needs. Gaps in services can be filled through the implementation of science-based programs that have been found to be the most effective in addressing specific risk and protective factors. These services can be identified through State or national prevention resources, such as DMHMRSAS, the Governor's Office for Substance Abuse Prevention or CSAP, and can be implemented through local community organizations.

4.3.4   *Program Evaluation*

The fourth step in the prevention planning process is evaluating community prevention efforts. Prevention efforts will only be effective through the implementation of services that have been proven to reduce problem behavior by targeting identified risk factors and enhancing protective factors. Continuing to regularly update the prevention needs assessment can provide prevention planners and evaluators with important process or short-term outcome evaluation data that will allow them to determine if their efforts are effectively closing the gap between identified needs and available services.

Information obtained from this Community Resource Assessment, together with the Archival Social Indicator Study and Community Youth Survey components of the Prevention Needs Assessment Studies, can assist the Commonwealth of Virginia in allocating prevention resources to close gaps in existing services, policies, and activities; buttress effective services, policies and activities; and assist planners and policymakers in prevention planning, resource allocation, evaluation activities, and policy development to help prevent ATOD use among Virginia's youth.

REFERENCES

Akers, L. 1977. *Deviant Behavior: A Social Learning Approach* (Second ed.). Belmont, CA: Wadsworth Press.

Arrowood, A.K. 1992. Prevalence of child abuse and variables related to physical and sexual abuse/assault among adolescent females in chemical dependency inpatient treatment. *Dissertation Abstracts International* 52(12):4265–4266A.

Arthur, M.W.; Shavel, D.A.; Tremper, M.; Hawkins, J.D.; and Hansen, C. 1997. Assessing State Prevention Resources. Unpublished manuscript prepared under contract from the National Center for the Advancement of Prevention, Center for Substance Abuse Prevention (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA).

Barea, Z.; Teichman, M.; and Rahav, G. 1992. Personality, cognitive, and interpersonal factors in adolescent substance use: A longitudinal test of an integrative model. *Journal of Youth and Adolescence* 21(2):187–201.

Belfer, M. 1993. Substance use with psychiatric illness in children and adolescents: Definitions and terminology. *American Journal of Orthopsychiatry* 63(1):70–79.

Benard, B. 1990. Fostering resiliency in kids: Protective factors in the family, school, and community. *Prevention Forum* 12(3):1–16.

Bronfenbrenner, U. 1979. *The Ecology of Human Development.* Cambridge: Harvard University Press.

Bureau of Justice Statistics. 1992. *Bureau of Justice Statistics Special Report: Survey of Youth in Custody, 1987, 1988.* Washington, DC: U.S. Department of Justice.

Catalano, R.F., and Hawkins, J.D. 1996. The social development model: A theory of antisocial behavior. In: Hawkins, J.D., ed. *Delinquency and Crime: Current Theories.* pp. 149–197.

Center for Substance Abuse Prevention. 2001. *Science-Based Substance Abuse Prevention: A Guide.* Rockville, MD: SAMHSA, CSAP, Division of Knowledge Development and Evaluation.

_____. National Center for the Advancement of Prevention. 2000. *2000 Annual Summary: Effective Prevention Principles and Programs.* Rockville, MD: U.S. DHHS, SAMHSA, CSAP.

_____. 1999. *Understanding Substance Abuse Prevention: Toward the 21st Century: A Primary on Effective Programs.* Rockville, MD: SAMHSA, CSAP, Center for Knowledge Development and Evaluation.

———. 1993. *CW Technical Report 7: Prevention Strategies Based on Individual Risk Factors for Alcohol and Other Drug Abuse.* Rockville, MD. Center for Substance Abuse Prevention.

Chin, K.; Lai, T.; and Rosue, M. 1990–1991. Social adjustment and alcoholism among Chinese immigrants in New York City. *The International Journal of Addiction* 25(5A and 6A):709–730.

Cochran, J. 1992. The effects of religiosity on adolescent self-reported frequency of drug and alcohol use. *Journal of Drug Issues* 22(1):91–104.

Cronin, C. 1993. The effect of living abroad on alcohol expectancies among American adolescents in Germany. *International Journal of Addictions* 28(2):167-174.

Dielman, T.E.; Butchart, A.T.; and Shope, J.T. 1993. Structural equation model tests of patterns of family interaction, peer alcohol use, and intrapersonal predictors of adolescent alcohol use and misuse. *Journal of Drug Education* 23(3):273–316.

Diez Roux, A.; Merkin, S.S.; Arnett, D.; Chambless, L.; Massing, M.; Nieto, F.J.; Sorlie, P.; Szklo, M.; Tyroler, H.; and Watson, R.L. 2001. Neighborhood of residence and incidence of coronary heart disease. *New England Journal of Medicine* 345(2):99–106.

Dillman, D.A. 1978. *Mail And Telephone Surveys; The Total Design Method.* John Wiley & Sons.

Fiorentine, R. 1993. *Assessing Drug and Alcohol Treatment Need of General and Special Populations: Conceptual, Empirical, and Inferential Issues.* Los Angeles, CA: UCLA Neuropsychiatric Institute, Drug Abuse Research Center.

Garbarino, J., and Kostelny, K. 1992. Child maltreatment as a community problem. *International Journal of Child Abuse and Neglect* 15(4):455–464.

Gilbert, M.J. 1992. "The Relevance of Culturally Sensitive Research in Alcohol Prevention Research in Minority Communities." Paper presented at the National Institute on Alcohol Abuse and Alcoholism Working Group on Alcohol Prevention Research in Ethnic Minority Communities, Washington, DC, May 18–19, 1992.

Gillmore, M.R.; Butler, S.S.; Lohr, M.J.; and Gilchrist, L. 1992. Substance use and other factors associated with risky sexual behavior among pregnant adolescents. *Family Planning Perspectives* 24 (6): 255–261, 268.

Goldsmith, H.F.; Lin, E.; Jackson, D.J.; Manderscheid, R.W.; and Bell, R.A. 1998. The future of mental health needs assessment. In: Goldsmith, H.F., Lin, E., Bell, R.A., and Jackson, D.J., eds. *Needs Assessment: Its Future* (DHHS Pub. No. ADM 88-1550) Washington, DC: US Government Printing Office.

Grant, B.F. and Dawson, B.A. 1997. Age of onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. Results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse* 9:103–110.

Greenwood, P.W. 1992. Substance abuse problems among high-risk youth and potential interventions. *Crime and Delinquency* 38(4):444–458.

Guyer, B., Schor, L., Messenger, K.P., Prenney, B., and Evans, F. 1984. Case assessment under the maternal and child health services block grant: Massachusetts. *American Journal of Public Health* 74:1014–1021.

Harlow, K.S., and Turner, M.J. 1993. Needs assessment revisited. *The Gerontologist*, 33(2):190–199.

Hawkins, J.D. 2001. *Science-Based Prevention: Testing Communities that Care. OJJDP Staff Briefing* [Staff briefing]. Washington, DC: Social Development Research Group.

Hawkins, J.D., Catalano, R., and Miller, J.Y. 1992. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin* 112(1):64–105.

Herberlein, T.A. and Baumgartner, R. 1978. Factors affecting response rates to mailed questionnaires: a quantitative analysis of the published literature. *American Sociology Review* 43:447–462.

Hirschi, T. 1969. *Causes of Delinquency*. Berkeley: University of California Press.

Hoyert, D.L.; Arias, E.; Smith, B.L.; Murphy, S.L.; and Kochanek, K.D. 2001. Final Data for 1999. National vital statistics reports; Vol. 49, No. 8 Hyattsville, MD. National Center for Health Statistics.

Institute of Medicine. 2001. *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us.* Washington, DC: National Academy Press.

Janlert, U., and Hammarstrom, A. 1992. Alcohol consumption among unemployed youths; results from a prospective study. *Br J Addict* 803:703–714.

Johnson, J. 1991. Preventive interventions for children at risk: Introduction. *International Journal of the Addictions* 25(4A):429–434.

Keefe, K. 1994. Perceptions of normative social pressure and attitudes toward alcohol use: Changes during adolescence. *Journal of Studies on Alcohol* 55(1):46–54.

Laurs, M.R. 1990–1991. Alcohol prevention in New Zealand: Working towards a national alcohol policy. *International Journal of the Addictions* 25(4A):513–532.

McKnight, J.L., and Kretzmann, J.P. 1990. *Mapping Community Capacity.* Evanston, IL: Northwestern University.

National Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control And Prevention, Office on Smoking and Health. 2001. *Cigarette Smoking-Related Mortality.* Atlanta, GA.

National Commission on Children. 1991. Beyond rhetoric: A new American agenda for children and families: Final Report. Washington, DC: Public Health Service.

Newcomb, M.D. and Felix-Ortiz, M. 1992. Multiple protective and risk factors for drug use and abuse: Cross-sectional and prospective findings. *Journal of Personality and Social Psychology* 63(2):280–296.

Office of Applied Studies, Substance Abuse and Mental Health Services Administration 2000. Patterns of Alcohol Use Among Adolescents and Associations with Emotional and Behavioral Problems. Rockville, MD.

_____. 2001a. Summary of Findings on the 2000 National Household Survey on Drug Abuse. Rockville, MD.

_____. November, 2001b. National Household Survey on Drug Abuse. The NHSDA Report. Youth Violence Linked to Substance Use. Rockville, MD.

Office of National Drug Control Policy. 1992. *Understanding Drug Prevention: An Office of National Drug Control Policy White Paper.* Washington, DC: White House.

Petersen, A., and Lupton, D. 1996. The new public health: Health and self in the age of risk. Allen and Unwin, St. Leonards, NSW.

Pryor, C.B. 1992. International exchange in preventing alcohol misuse. *Journal of Alcohol and Drug Education* 37(3):114–125.

Social Development Research Group. 1994–2001. Research and programs and the social development strategy [Online]. Computing & Communications, University of Washington, Seattle, Washington. Available: depts.washington.edu/sdrg/index.html [2001, 7/21/2001].

Suedfeld, P. (ed.). 1991. *Unsolved Critical Issues in Substance Use Intervention: Special Issue on Environmental Factors in Substance Misuse and its Treatment.* New York: Marcel Dekker.

Sutherland, E.H. 1956. Development of the theory. In: Cohen, A.K., Lindesmith, A., and Schuessler, K., eds. *The Sutherland Papers.* Bloomington, IN: Indiana University Press. pp. 13–29.

Thomas, B.S., and Hsiu, L.T. 1993. Role of selected risk factors in predicting adolescent drug use and its adverse consequences. *International Journal of the Addictions* 28(14):1549–1563.

U.S. Department of Health and Human Services Press Office (2002). HHS Fact Sheet. Substance Abuse—A National Challenge: Prevention, Treatment, and Research at HHS.

Uehara, E.S.; Smukler, M.; and Newman, F.L. 1994. Linking resource use to consumer level of need: Field test of the level-of-need-care assessment (LONCA) method. *Journal of Consulting and Clinical Psychology*, 62(4), 695–709.

World Health Organization and Canadian Public Health Association. 1996. Ottawa Charter for Health Promotion. *Health Promotion* 1:iii–v.

APPENDIX A
LETTERS TO PHASE I RESPONDENTS REQUESTING CONTACT INFORMATION ON PHASE II RESPONDENTS

Date

«name»
«Agency»
«PO_Box»
«Address»
«City», «State» «Zip_Code»

Dear Name,

My name is <name> and I am the Prevention Needs Assessment Coordinator for the VA Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). As you may remember, the DMHMRSAS has a contract with the Federal Center for Substance Abuse Prevention (CSAP) to conduct a statewide prevention needs assessment. The needs assessment involves three studies: 1) a community resource assessment, 2) a community youth survey, and 3) an archival social indicator database.

The purpose of the resource assessment is to collect information on available resources (e.g., programs, services, technical assistance, staff, funding streams, etc.) that target the prevention of risk factors associated with problem behavior (e.g., family conflict, low commitment to school, delinquency, community disorganization, etc.). The results of the community resource assessment will be integrated with the results of the other two studies, to identify gaps in services across the Commonwealth of Virginia.

Last year, for Phase I of the Community Resource Assessment, <name> conducted an interview with you to collect information on prevention resources available at the state level. We want to again thank you for your time and input. The information you provided has been extremely valuable in assessing available prevention resources in the Commonwealth.

We are now ready to move onto Phase II of the study, which is to collect information on resources that are available at the local level. We would like to send out Prevention Community Resource Assessment surveys to the individuals knowledgeable about resources available in the following localities: Arlington, Prince William, Rappahannock Area, Northern Neck/Middle Peninsula, District 19, Crossroads, Valley, Blue Ridge, and Planning District 1.

Please provide the names of directors/managers of prevention resources, as well as their contact information, on the attached sheet and send it to me @ Office of Research and Evaluation, Department of Mental Health Mental Retardation and Substance Abuse Services, P.O. Box 1797, Richmond, VA 23218-1797 by Friday, March 16, 2001.   .

Your cooperation in this matter is greatly appreciated. If you have any questions or concerns please contact me at <phone number and email>.

Sincerely,

Program Director/Manager Contact Sheet

Arlington

<u>Name/Title</u>	<u>Address</u>	<u>Phone</u>	<u>E-mail</u>

1)_____ _____
_____ _____

2)_____ _____
_____ _____

3)_____ _____
_____ _____

4)_____ _____
_____ _____

5)_____ _____
_____ _____

Prince William

<u>Name/Title</u>	<u>Address</u>	<u>Phone</u>	<u>E-mail</u>

1)_____ _____
_____ _____

2)_____ _____
_____ _____

3)_____ _____
_____ _____

4)_____ _____
_____ _____

5)_____ _____
_____ _____

Rappahannock Area

<u>Name/Title</u>	<u>Address</u>	<u>Phone</u>	<u>E-mail</u>

1)_____ _____

_____ _____

2)_____ _____

_____ _____

3)_____ _____

_____ _____

4)_____ _____

_____ _____

5)_____ _____

_____ _____

Northern Neck/Middle Peninsula

<u>Name/Title</u>   <u>Address</u>   <u>Phone</u>   <u>E-mail</u>

1)_____ _____

_____ _____

2)_____ _____

_____ _____

3)_____ _____

_____ _____

4)_____ _____

_____ _____

5)_____ _____

_____ _____

District 19

<u>Name/Title</u>   <u>Address</u>   <u>Phone</u>   <u>E-mail</u>

1)_____ _____

_____ _____

2)_____ _____

_____ _____

3)_____ _____

_____ _____

4)_____ _____
_____ _____

5)_____ _____
_____ _____

Crossroads

Name/Title	Address	Phone	E-mail

1)_____ _____
_____ _____

2)_____ _____
_____ _____

3)_____ _____
_____ _____

4)_____ _____
_____ _____

5)_____ _____
_____ _____

Valley

Name/Title	Address	Phone	E-mail

1)_____ _____
_____ _____

2)_____ _____
_____ _____

3)_____ _____
_____ _____

4)_____ _____
_____ _____

5)_____ _____
_____ _____

Blue Ridge

Name/Title	Address	Phone	E-mail
1)_____ _____	_____ _____		
2)_____ _____	_____ _____		
3)_____ _____	_____ _____		
4)_____ _____	_____ _____		
5)_____ _____	_____ _____		

Planning District 1

Name/Title	Address	Phone	E-mail
1)_____ _____	_____ _____		
2)_____ _____	_____ _____		
3)_____ _____	_____ _____		
4)_____ _____	_____ _____		
5)_____ _____	_____ _____		

APPENDIX B
PHASE I DATA COLLECTION INSTRUMENT

INTRODUCTORY STATEMENT TO PERSONAL INTERVIEW

Before we get started, I would like to give you information on the purpose of the interview and the Resource Assessment study. As you know, my name is Karyn Tiedeman and I work in the Office of Research and Evaluation in the Department of Mental Health, Mental Retardation, and Substance Abuse Services. As I explained the last time we spoke, the purpose of this interview is to collect information on prevention resources in Virginia. The interview is funded through a contract with CSAP and is one of three studies that will be integrated to form a comprehensive statewide needs assessment. We have contacted you to participate in the study because of your extensive knowledge of the prevention field. Thus, your participation in the study is appreciated particularly because we know that your time is valuable.

As I already stated, this telephone interview is designed to assist States to assess prevention resources in <<Virginia>>. A prevention resource is a program, service, or activity that helps reduce the likelihood that people will engage in problem behaviors, such as drug use, crime, delinquency, or violence. This survey covers a broad range of programs and services that address many different issues, such as prenatal care, family support services, academic achievement, after-school recreation, community policing, and others. Each of these various types of programs and services may help to prevent problem behaviors, and therefore is considered to be a prevention resource. The information gathered from this survey will help State and local agencies identify gaps in services and plan for services to address local prevention needs.

VIRGINIA COMMUNITY RESOURCE ASSESSMENT

TELEPHONE INTERVIEW

State-Level Prevention Program Administrators

(Questions in bold are additional questions not part of the Core CSAP CRA items)

GENERAL INFORMATION

1. **Name of agency/organization:** _____

2. **Street address. city, and ZIP Code:** _____

    _____

3. **Mailing address, city, and ZIP Code:** _____

    _____

4. **Phone:** _____

5. **What is your title?** _____

6. **How long have you been in your current position?** _____

    7. **How long have you been in the prevention field?** _____ **(# of years)**

    8. **What do you think are the greatest prevention needs in the State?**

        _____

        _____

        _____

    9. **What do you think your office's main focus or objectives are?**

        _____

        _____

        _____

(MAKE SURE PREVENTION OBJECTIVES ARE ADDRESSED)

10. What types of training or technical assistance does your office provide to the field?

_____

_____

_____

11. What role does your office play in developing or implementing laws and policies that may influence prevention resources?

_____

_____

_____

12. What laws or policies affect your office's delivery of prevention resources?

_____

_____

_____

STAFFING

13. How many paid staff, in full-time equivalents, are employed in your agency? _____

14. How many paid staff, in full-time equivalents, are employed in your office? _____

15. How many paid staff in your agency, in full-time equivalents, would you say

are devoted to prevention? _____

16. How many paid staff in your office, in full-time equivalents, would you say

are devoted to prevention? _____

17. How many volunteer staff in your agency are devoted to prevention? _____

18. How many volunteer staff in your agency are devoted to prevention? _____

PROGRAMS/SERVICES PROVIDED

19. Does your department engage in the following youth-focused programs/services?

No   Yes
( )   ( )   Supervised after-school recreation programs _(e.g., organized sports, clubs)_

( )   ( )   Drug-free social and recreational activities _(e.g., drug-free dances, "Just Say No" clubs, prom and graduation contracts)_

( )   ( )   Youth adventure-based programs _(e.g., outdoor challenge activities such as wilderness courses or ropes courses)_

( )   ( )   Intergenerational _(e.g., shared activities between youth and elderly persons)_

( )　( )　Mentoring

( )　( )　Career/job skills training

( )　( )　Youth community service programs *(e.g., volunteer work, service learning)*

( )　( )　Peer leadership/peer helper programs

( )　( )　Life skills/social skills training (e.g., assertiveness, communication, drug refusal, problem-solving, or conflict resolution skills training)

( )　( )　Teen drop-in centers

( )　( )　Tutoring programs

( )　( )　Youth support groups *(e.g., Alateen, COSA)*

( )　( )　Youth community action groups *(e.g., SADD, youth councils)*

Other: _____

Other: _____

Other: _____

20. Does your department engage in the following family-focused programs/services?

No　Yes

( )　( )　Prenatal/infancy *(e.g., maternal and child health care, nutrition, and child development)*

( )　( )　Early childhood education *(e.g., early enrichment or pre-school programs)*

( )　( )　Parenting/family management training *(e.g., supervision, rule-setting, and discipline skills)*

( )　( )　Premarital counseling

( )　( )　Family support *(e.g., family planning, home visits from health or social service workers, housing, child care)*

Other: _____

Other: _____

Other: _____

21. Do your programs engage in the following school-focused programs/services?

No　Yes

( )　( )　Organizational change in schools *(e.g., school-community partnerships, school management teams involving administrators, teachers, counselors, and parents, and parental involvement)*

( )　( )　Classroom organization, management, and instructional practices *(e.g., interactive teaching, proactive classroom management, cooperative learning)*

( )　( )　School behavior management *(e.g., structured playground activities, discussion of weekly behavioral report cards, behavioral contracting)*

( )　( )　School transition *(e.g., special homerooms or "schools within schools" for new students)*

( )　( )　Development of school policies that discourage substance abuse

( )　( )　Enforcement of school policies that discourage substance abuse

Other: _____

Other: _____

Other: _____

22. Does your program engage in the following community-focused programs/services?

No   Yes
( )   ( )   Development of community laws and policies that discourage substance abuse

( )   ( )   Enforcement of community laws and policies that discourage substance abuse

( )   ( )   Media campaigns *(e.g., posters, public service announcements, advertisements, commercials)*

( )   ( )   Information dissemination *(e.g., brochures, fact sheets, videos, presentations, Clearinghouse)*

( )   ( )   Community mobilization *(e.g., coalition building, neighborhood watch)*

( )   ( )   Community development/capacity building *(e.g., training and technical assistance to community groups and organizations)*

( )   ( )   Provide or assist with community policing programs/services *(e.g., foot or bicycle patrols, training to police in child development and crisis management)*

Other: _____

Other: _____

Other: _____

BUDGET:

23. What was the overall budget for your office for the last fiscal or calendar year? _____

24. What percentage of the overall budget was devoted to <u>prevention</u>? _____

25. Does your department receive funding from the following sources? (Please check all that apply)

_____ **State Agency**

_____ **Direct Federal grants or contracts**

_____ **Local/municipal funds**

_____ **Program fees**

_____ **Foundations (e.g., United Way) or individual contributions**

_____ **Other (please specify):** _____

26. We'd like to know how the level of prevention funding has changed in your office compared to last year. From the following list please indicate the answer that best fits the changes that have taken place;

( ) **Doubled or more than doubled**   ( ) **Decreased somewhat**
( ) **Increased somewhat**   ( ) **Was cut in half or more than half**
( ) **Stayed about the same**

27. What brought about this change in funding?

_____

_____

_____

AGENCY/COMMUNITY COLLABORATION:

28. Does your agency currently participate with other community organizations in <u>joint planning</u> around prevention?

YES→ CONTINUE
NO → SKIP TO QUESTION ON TRAINING
REFUSED→ SKIP TO QUESTION ON TRAINING
DON'T KNOW → SKIP TO QUESTION ON TRAINING

If yes, which of the following types of agencies does your office participate in joint prevention planning?

Does your agency participate in <u>joint planning on prevention</u> with…	YES	NO	REFUSED	DON'T KNOW
Schools…				
Youth Service Bureau…				
Local Prevention Council…				
Police or Juvenile Justice Department…				
Religious Organizations…				
Regional substance abuse council…				
Local recreation department…				
Local health department…				
Local social service department…				
Private non-profit social service agency…				
Private business or corporation…				
Other organizations…(SPECIFY):				

TRAINING:

29. **Over the past year, how much training has your staff received in the following areas?**

Training	None/Not At All	A Little	Some	A lot
Asset building				
Leadership development				
Coalition building				
Program implementation				
Fundraising/development				
Program monitoring/evaluation				
Risk/protective factor prevention framework				
Cultural awareness/diversity				
Effective research-based prevention approaches				
Other (describe)				
Other (describe)				

DATA/PLANNING:

30. Please indicate whether you collect and/or use the following types of information for prevention planning purposes and/or whether you provide these types of information to others:

Types of Information	Collect Data	Use data for planning	Provide data to others
Prevention needs (i.e., risk and protective factors)			
Drug use and crime rates			
Clearinghouse/resource center			
Effective research-based prevention strategies			
Populations Served			
Program Descriptions			
Program monitoring (e.g., participant satisfaction; attendance)			
Program evaluation (e.g., program effectiveness)			

31. If you collect data for program effectiveness, how do you determine whether the program is working? I'm going to read you a list of times that you may ask program to collect data for program effectiveness, please indicate which item best matches your data collection strategy.

( )   Collect data ONLY before program begins
( )   Collect data ONLY immediately after the program ends (e.g., satisfaction surveys)

( )   Compare differences in data collected before the program begins and immediately after the program ends

( )   Conduct long-term follow up (e.g. months or years after program ends)

( )   Collect anecdotal evidence (e.g. informal discussion with participants)

( )   Collect data multiple times during the program

( )   Other, please specify

BARRIERS:

32. Many programs/services report that there are barriers that prevent or limit them from serving some members of the target population. Please indicate the extent to which each of the following issues is a barrier to effective delivery of prevention services in your program/service.

	Not a Barrier	Minor Barrier	Moderate Barrier	Significant Barrier
1. Lack of available program slots	( )	( )	( )	( )
2. Limited hours of operation	( )	( )	( )	( )
3. Insufficient staff due to lack of funding	( )	( )	( )	( )
4. Staff turnover	( )	( )	( )	( )
5. Program eligibility criteria are too restrictive	( )	( )	( )	( )
6. Lack of public awareness of services offered	( )	( )	( )	( )

	Not a Barrier	Minor Barrier	Moderate Barrier	Significant Barrier
7. Cultural or language differences	( )	( )	( )	( )
8. Lack of transportation to and from services	( )	( )	( )	( )
9. Service fee is not affordable	( )	( )	( )	( )
10. Perceived social stigma	( )	( )	( )	( )
11. Lack of community interest	( )	( )	( )	( )
12. Program participants drop out	( )	( )	( )	( )
13. Waiting lists	( )	( )	( )	( )
14. Insufficient collaboration with schools	( )	( )	( )	( )
15. Insufficient collaboration with other community organizations	( )	( )	( )	( )
16. Program location is unsafe	( )	( )	( )	( )
17. Lack of childcare facilities	( )	( )	( )	( )
18. Other barrier (please specify) _____	( )	( )	( )	( )

THANK YOU FOR YOUR ASSISTANCE

APPENDIX C
PHASE II DATA COLLECTION INSTRUMENT

VIRGINIA
COMMUNITY RESOURCE SURVEY

PROGRAM DIRECTOR

INTRODUCTORY STATEMENT

This survey is designed to assist States to assess prevention resource in <<COMMUNITY, STATE>>. A prevention resource is a program, service, or activity that helps reduce the likelihood that people will engage in problem behaviors, such as drug use, crime, delinquency, or violence. This survey covers a broad range of programs and services that address many different issues, such as prenatal care, family support services, academic achievement, after-school recreation, community policing, and others. Each of these various types of programs and services may help to prevent problem behaviors, and therefore is considered to be a prevention resource. The information gathered from this survey will help State and local agencies identify gaps in services and plan for services to address local prevention needs.

This survey is an effort of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services. The survey is funded through the Needs assessment grant awarded by the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration, a branch of the Federal Department of Health and Human Services.

VIRGINIA
COMMUNITY RESOURCE SURVEY

PROGRAM DIRECTOR

GENERAL INFORMATION

1. Name of agency/organization: _____

2. Street address, city, and ZIP Code: _____

    _____

3. Mailing address, city, and ZIP Code: _____

    _____

4. Phone Number: _____

5. E-mail Address: _____

6. How long have you been director at this program? _____ (# of years)

7. How long have you been in the prevention field? _____ (# of years)

8. Do you have any special training in prevention?   ( ) No   ( ) Yes

9. If YES, what kind of training do you have? _____

    _____

10. What geographical region does your program cover?

    Locality(ies): _____

    School district(s): _____

11. What is the street address(es) where this program delivers its services?
    _____
    _____

12. What do you think are the greatest prevention needs in your locality?

    _____
    _____
    _____

13. What do you think are your program's main focus or objectives? (For example, to increase involvement in positive social activi ties, such as sports, clubs or recreation)

    _____
    _____
    _____

PREVENTION PROGRAMS/SERVICES

This next section asks about **prevention resources**. A **prevention resource** is a program, service, or activity that helps reduce the likelihood that people will engage in problem behaviors, such as drug use, crime, delinquency, or violence.

14. Does your program engage in the following youth-focused programs/services?

No   Yes
( )   ( )   Supervised after-school recreation programs (e.g., organized sports, clubs)

( )   ( )   Drug-free social and recreational activities (e.g., drug-free dances, "Just Say No" clubs, prom and graduation contracts)

( )   ( )   Youth adventure-based programs (e.g., outdoor challenge activities such as wilderness courses or ropes courses)

( )   ( )   Intergenerational (e.g., shared activities between youth and elderly persons)

( )   ( )   Mentoring

( )   ( )   Career/job skills training

( )   ( )   Youth community service programs (e.g., volunteer work, service learning)

( )   ( )   Peer leadership/peer helper programs

( )   ( )   Life skills/social skills training (e.g., assertiveness, communication, drug refusal, problem-solving, or conflict resolution skills training)

( )   ( )   Teen drop-in centers

( )   ( )   Tutoring programs

( )   ( )   Youth support groups (e.g., Alateen, COSA)

( )   ( )   Youth community action groups (e.g., SADD, youth councils)

Other: _____

Other: _____

15. Does your program engage in the following family-focused programs/services?

No   Yes
( )   ( )   Prenatal/infancy (e.g., maternal and child health care, nutrition, and child development)

( )   ( )   Early childhood education (e.g., early enrichment or pre-school programs)

( )   ( )   Parenting/family management training (e.g., supervision, rule-setting, and discipline skills)

( )   ( )   Premarital counseling

( )   ( )   Family support (e.g., family planning, home visits from health or social service workers, housing, child care)

Other: _____

Other: _____

16. Does your program engage in the following school-focused programs/services?

No   Yes

( )   ( )   Organizational change in schools (e.g., school-community partnerships, school management teams involving administrators, teachers, counselors, and parents, and parental involvement)

( )   ( )   Classroom organization, management, and instructional practices (e.g., interactive teaching, proactive classroom management, cooperative learning)

( )   ( )   School behavior management (e.g., structured playground activities, discussion of weekly behavioral report cards, behavioral contracting)

( )   ( )   School transition (e.g., special homerooms or "schools within schools" for new students)

( )   ( )   Development of school policies that discourage substance abuse

( )   ( )   Enforcement of school policies that discourage substance abuse

Other: _____

Other: _____

17. Does your program engage in the following community-focused programs/services?

No   Yes

( )   ( )   Development of community laws and policies that discourage substance abuse

( )   ( )   Enforcement of community laws and policies that discourage substance abuse

( )   ( )   Media campaigns (e.g., posters, public service announcements, advertisements, commercials)

( )   ( )   Information dissemination (e.g., brochures, fact sheets, videos, presentations, Clearinghouse)

( )   ( )   Community mobilization (e.g., coalition building, neighborhood watch)

( )   ( )   Community development/capacity building (e.g., training and technical assistance to community groups and organizations)

( )   ( )   Provide or assist with community policing programs/services (e.g., foot or bicycle patrols, training to police in child development and crisis management)

Other: _____

Other: _____

18. Please indicate which ONE of the following program/service categories best describes your program:

(CIRCLE ONLY ONE)

Individual/Peer

Supervised after-school recreation programs*)*   Peer leadership/peer helper programs
Drug-free social and recreational activities   Life skills/social skills training
Youth adventure-based programs   Teen drop-in centers
Intergenerational   Tutoring programs
Mentoring   Youth support groups
Career/job skills training   Youth community action groups
Youth community service programs   Other: _____

Family

Prenatal/infancy   Premarital counseling
Early childhood education   Family support
Parenting/family management *training*   Other: _____

School

Organizational change in schools   Development of school policies that discourage
Classroom organization, management, and   substance abuse
    instructional practices   Enforcement of school policies that discourage
School behavior management   substance abuse
School transition   Other: _____

Community

Development of community laws and policies that
    discourage substance abuse
Enforcement of community laws and policies that
    discourage substance abuse
Media campaigns
Information dissemination
Community mobilization
Community development/capacity building
Provide or assist with community policing
    programs/services
Other: _____

19. How many weeks did this program operate during the past 12 months? _____

20. On average, how long does each session, meeting, or event last? (convert to hours) _____

21. On average, how often does each session, meeting, or event take place?

Please complete one of the following:

        Day(s) per week   _____

        Day(s) per month   _____

22. How many participants took part in your program in the last 12 months?_____

23. Please identify the *primary* population(s) that your program served (Check all that apply).

General Population		Community	
		Criminally Involved Adults	
School		Economically Disadvantaged Groups	
Preschool Students		Civic Groups	
Elementary School Students		Coalitions	
Middle/Junior High School Students		Gays/Lesbians	
High School Students		Government/Elected Officials	
College Students		Immigrants and Refugees	
		Law Enforcement/Military	
Youth		Migrant Workers	
COSAs/Children of Substance Abusers		Older Adults	
Delinquent/Violent Youth		People Using Substance (excluding those in need of treatment)	
Foster Children		People with Disabilities	
Homeless/Runaway Youth		Physically/Emotionally/Sexually Abused People	
Economically Disadvantaged Youth		Pregnant Women	
School Dropouts		Religious Groups	
Pregnant Teenagers		Rural/Isolated Populations	
Students At Risk of Dropping Out of School		Urban/Inner-City Populations	
Youth/Minors Not Included Under Other Categories		Women of Childbearing Age	
Families		**Business/Work Populations**	
Parents/Families		Business and Industry	
		Health Care Professionals	
		Managed Care Organizations	
		Teachers/Administrators/Counselors	
		Other (please specify):	

24. Where did this program take place? (Check all that apply.)

( ) In school, during school hours   ( ) In school, after school hours

( ) Out-of-school site

25. Please estimate the <u>percentage</u> of program participants in each of the following age groups:

          % 0-4 years old   % 18-20 years old

          % 5-11 years old   % 21-24 years old

          % 12-14 years old   % 25-54 years old

          % 15-17 years old   % 45-64 years old

                                        % 65 and over

26. Please estimate the <u>percentage</u> of program participants that were:

          % Male   % Female

27. Please estimate the <u>percentage</u> of program participants that were:

          % White, not of Hispanic Origin   % Hispanic/Latino

          % Black/not of Hispanic Origin   % Multiracial/Multiethnic

          % Asian or Pacific Islander

          % Native American (American
                  Indian or Alaska Native)

STAFFING:

28. Please indicate the numbers of prevention staff and the average number of hours per week they worked in your program during the last 12 months:

	Number of employees		Average hours worked per week	
	Adults	*Youth*	*Adults*	*Youth*
Paid full time				
Paid part time				
Volunteers				

29. What, if any, credentials do you require of your prevention staff?

_____

_____

BUDGET:

30. Please estimate the annual budget for this program for the past year (including planning administrative, and support time as well as time devoted to direct service).

$_____

DATA AND EVALUATION:

31. Does this program use data for any of the following purposes? (Check all that apply)

( ) Does not use data   ( ) Grant or contract proposals

( ) Reporting to key stakeholders   ( ) Determine program effectiveness (outcome
      evaluation)

( ) Meet funding requirements   ( ) Formal "needs assessment" study

( ) Program planning   ( ) Other (Please specify) _____
    _____

( ) Community mobilization

( ) Provide a description of program activities and participants served (process evaluation)

32. Is the evaluation conducted by in-house staff or is it contracted out?

( ) In-house staff

( ) Contracted out (to whom?) _____

( ) We don't conduct any evaluations

33. When are the data collected?

( ) Before the program begins   ( ) Some time (e.g., months, years)
    after the end of the program

( ) Just after the program has ended   ( ) Other: _____

( ) During the program   ( ) Don't Know

SUBSTANCE ABUSE RELATED OBJECTIVES:

34. To what extent did your program/service address the following objectives?

(**NOTE**: **A main focus** refers to an objective addressed by the program that is a specific focus or objective of the program. **Not a main focus, but addressed** refers to an objective addressed by the program, but that is not a specific focus of the program. **Not addressed** refers to an objective that is not addressed at all by the program.)

Objective	A Main Focus	Not a Main Focus, but Addressed	Not Addressed
A. Peer and Individual Domain			
1. Prevent or delay the first use of ATOD	( )	( )	( )
2. Strengthen perceptions about the harmful effects of ATOD use	( )	( )	( )
3. Strengthen attitudes against ATOD use	( )	( )	( )
4. Prevent anti-social behaviors	( )	( )	( )
5. Strengthen attitudes against antisocial behavior (e.g., delinquency, violence)	( )	( )	( )
6. Increase involvement in positive social activities, such as sports, clubs, etc	( )	( )	( )
7. Increase involvement in religious activities	( )	( )	( )
8. Increase the number of youth who have positive relationships with adults	( )	( )	( )
9. Reduce involvement in delinquent peer groups	( )	( )	( )
10. Reduce involvement in drug-using peer groups	( )	( )	( )
11. Reduce symptoms of depression	( )	( )	( )
12. Reduce rebelliousness among youth	( )	( )	( )
13. Improve social skills (e.g., communication, anger management, social problem solving)	( )	( )	( )
14. Increase youths' awareness of peer norms opposed to ATOD use	( )	( )	( )
15. Provide alternative activities that are thrilling and socially acceptable (e.g., rock climbing, extreme sports, wilderness courses, ropes courses)	( )	( )	( )

Objective	A Main Focus	Not a Main Focus, but Addressed	Not Addressed

B. Family Domain

1. Reduce ATOD use among adult family members .... ( )   ( )   ( )

    2. Improve parents' family management skills (e.g., supervision, rules, discipline)... ( )   ( )   ( )

    2. Improve parents' and children's family communication skills .... ( )   ( )   ( )

    3. Change parental attitudes towards ATOD use among youth .... ( )   ( )   ( )

    4. Improve parents' ability to provide opportunities for positive family involvement… .... ( )   ( )   ( )

    5. Improve parents' ability to reward positive family involvement .... ( )   ( )   ( )

    6. Reduce marital conflict .... ( )   ( )   ( )

C. School Domain

7. Establish, communicate, and enforce clear policies regarding ATOD use .... ( )   ( )   ( )

    8. Improve academic skills .... ( )   ( )   ( )

    9. Improve student commitment to education .... ( )   ( )   ( )

    10. Increase opportunities for positive youth participation in school .... ( )   ( )   ( )

    11. Increase rewards for positive youth participation in schools .... ( )   ( )   ( )

    12. Increase opportunities for positive youth participation in the classroom..... ( )   ( )   ( )

    13. Increase positive parental involvement in school .... ( )   ( )   ( )

D. Community Domain

14. Improve adjustment to a new home or school .... ( )   ( )   ( )

    15. Reduce youth access to ATOD .... ( )   ( )   ( )

    16. Increase opportunities for positive youth involvement in the community.... ( )   ( )   ( )

    17. Increase rewards for positive youth involvement in the community .... ( )   ( )   ( )

    18. Develop or strengthen community laws that restrict ATOD use .... ( )   ( )   ( )

    19. Strengthen community norms and/or attitudes against ATOD use............ ( )   ( )   ( )

    20. Improve neighborhood safety, organization and/or sense of community ... ( )   ( )   ( )

BARRIERS:

33. Many programs/services report that there are barriers that prevent or limit them from serving some members of the target population. Please indicate the extent to which each of the following issues is a barrier to effective delivery of prevention services in your program/service.

	Not a Barrier	Minor Barrier	Moderate Barrier	Significant Barrier
19. ....Lack of available program slots	( )	( )	( )	( )
20. Limited hours of operation	( )	( )	( )	( )

	Not a Barrier	Minor Barrier	Moderate Barrier	Significant Barrier
21. Insufficient staff due to lack of funding	( )	( )	( )	( )
22. Staff turnover	( )	( )	( )	( )
23. Program eligibility criteria are too restrictive	( )	( )	( )	( )
24. Lack of public awareness of services offered	( )	( )	( )	( )
25. Cultural or language differences	( )	( )	( )	( )
26. Lack of transportation to and from services	( )	( )	( )	( )
27. Service fee is not affordable	( )	( )	( )	( )
28. Perceived social stigma	( )	( )	( )	( )
29. Lack of community interest	( )	( )	( )	( )
30. Program participants drop out	( )	( )	( )	( )
31. Waiting lists	( )	( )	( )	( )
32. Insufficient collaboration with schools	( )	( )	( )	( )
33. Insufficient collaboration with other community organizations	( )	( )	( )	( )
34. Program location is unsafe	( )	( )	( )	( )
35. Lack of childcare facilities	( )	( )	( )	( )
36. Other barrier (please specify) _____	( )	( )	( )	( )

COLLABORATION:

34. Does your program co-sponsor events or activities with other community organizations?

( ) No   ( ) Somewhat   ( ) A Lot

35. Does your program participate in joint planning with other community organizations?

( ) No   ( ) Somewhat   ( ) A Lot

36. Does your program share funding or staff with other community organizations?

( ) No   ( ) Somewhat   ( ) A Lot

THANK YOU FOR YOUR ASSISTANCE

APPENDIX D
INTRODUCTORY LETTERS SENT TO PHASE I RESPONDENTS

Date

«name»
«Agency»
«PO_Box»
«Address»
«City», «State» «Zip_Code»

Dear Name:

I am writing to inform you of the implementation of a Prevention Community Resource Assessment. As you may know, the Department of Mental Health, Mental Retardation, and Substance Abuse Services recently received a contract from the Center of Substance Abuse Prevention to conduct a statewide prevention needs assessment. The purpose of the resource assessment is to collect information on available programs and services that focus on the prevention of alcohol, tobacco, and other drug use and/or associated problems (e.g., family conflict, low commitment to school, delinquency, community disorganization). The results of the Community Resource Assessment will be integrated with the results of two other studies, a Youth Survey and a Social Indicator Database, to form a comprehensive prevention needs assessment.

You are receiving this letter to request your participation in the Community Resource Assessment. Your participation in the Community Resource Assessment is essential for the successful completion of the needs assessment. We also believe that your participation will be a great benefit to you and the prevention field. Resource assessments can assist prevention planners and providers to (1) examine the match between existing prevention policies and programs and identified prevention needs, (2) allocate prevention resources to close gaps in existing policies and programs, and (3) improve prevention accountability and track costs.

Your participation in the study would involve a personal interview to collect general information on prevention services provided by your agency. Karyn Tiedeman, is conducting the Community Resource Assessment study. She will contact you in the near future to schedule a convenient time to complete a personal interview. The interview will last approximately 45 minutes.

We would like to thank you for taking time out of your busy schedule. If you have any further questions or comments, feel free to contact me anytime at (804) 786-8336. Thank you for your valuable time; it is greatly appreciated.

Sincerely,

Karyn I. Tiedeman, PhD
Needs Assessment Coordinator
Office of Research and Evaluation
Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services

Appendix E
Letter Sent to Phase I Participants
with Copy of Phase I Survey

Date

«name»
«Agency»
«PO_Box»
«Address»
«City», «State» «Zip_Code»

Dear Name,

As we discussed on the telephone, I have enclosed a copy of the interview questions for you to review at your convenience. As a reminder, your interview is scheduled for TIME on DATE.

I would like to thank you again for taking time out of your busy schedule. Your time is greatly appreciated. It was a pleasure speaking with you and I look forward to your interview. I would also like to remind you that your responses are strictly confidential. If you have any further questions or comments, feel free to contact me anytime at (804) 786-8019.

   Sincerely,

   Karyn I. Tiedeman, PhD
   Needs Assessment Coordinator
   Office of Research and Evaluation
   Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services

APPENDIX F
INTRODUCTORY LETTER SENT TO POTENTIAL PHASE II PARTICIPANTS

Date

«name»
«Agency»
«PO_Box»
«Address»
«City», «State» «Zip_Code»

Dear Name,

I am writing to inform you of the implementation of a Prevention Community Resource Assessment. As you may know, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) recently received a contract from the Center of Substance Abuse Prevention to conduct a statewide prevention needs assessment. The purpose of the resource assessment is to collect information on available programs and services that focus on the prevention of alcohol, tobacco, and other drug use and/or associated problems (e.g., family conflict, low commitment to school, delinquency, community disorganization). The results of the Community Resource Assessment will be integrated with the results of two other studies, a Youth Survey and a Social Indicator Database, to form a comprehensive prevention needs assessment.

You are receiving this letter to request your participation in the Community Resource Assessment. Your participation in the Community Resource Assessment is essential for the successful completion of the needs assessment. We also believe that your participation will be a great benefit to you and the prevention field. Resource assessments can assist prevention providers to examine the match between existing prevention programs and identified prevention needs, in order to strengthen the effectiveness of existing programs.

Your participation in the study would involve completing a survey designed to collect program process information. Karyn Tiedeman, the Needs Assessment Coordinator at the DMHMRSAS is conducting the Community Resource Assessment study and will send the survey out in the next two weeks. The survey will take approximately 45 minutes to complete.

We would like to thank you for taking time out of your busy schedule. If you have any further questions or comments, feel free to contact me anytime at (804) 786-8336. Thank you for your valuable time; it is greatly appreciated.

Sincerely,

Karyn I. Tiedeman, PhD
Needs Assessment Coordinator
Office of Research and Evaluation
Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services

APPENDIX G
COVER LETTER WITH SURVEY TO PHASE II PARTICIPANTS

Date

«First_name» «Last_name»
Insert Program Name
«Agency»
«PO_Box»
«Address»
«City», «State»   «ZipCode»

Dear «First_name» «Last_name»:

I am writing to inform you of the implementation of a Prevention Community Resource Assessment. As you may know, the Department of Mental Health, Mental Retardation, and Substance Abuse Services received a contract from the Center of Substance Abuse Prevention to conduct a statewide prevention needs assessment. The purpose of the resource assessment is to collect information on available resources (e.g., programs, services, technical assistance, staff, funding streams, etc.) that target risk and protective factors (e.g., family conflict, low commitment to school, transitions and mobility) related to alcohol, tobacco, and other drug use and/or associated problems (e.g., delinquency, teen pregnancy, school dropout). The results of the Community Resource Assessment will be integrated with the results of two other studies, a Youth Survey and a Social Indicator Database, to form a comprehensive prevention needs assessment.

You are receiving this letter to request your participation in the Community Resource Assessment. Your participation in the Community Resource Assessment is essential for the successful completion of the needs assessment. We also believe that your participation will be a great benefit to you and the prevention field. Resource assessments can assist prevention planners and providers to (1) examine the match between existing prevention policies and programs and identified prevention needs, (2) allocate prevention resources to close gaps in existing policies and programs, and (3) improve prevention accountability and track costs.

Your participation in the study involves completing the attached survey, designed to collect information about your program(s). We are particularly interested in programs in the following localities**: Augusta County, Arlington County, Amelia County, Botetourt County, Caroline County, Cumberland County, Dinwiddie County, Hampton, Mathews County, Newport News, Petersburg, Prince William County, Richmond County, Roanoke County, Scott County, Stafford County, Staunton, and Wise County**. The survey will take approximately 45 minutes to complete. After completing the survey, please place it in the return envelope (enclosed) and return it by October 31, 2001. **Please use a paperclip to bind the survey and Do Not Staple**.

We would like to thank you for taking time out of your busy schedule to assist us in this study. If you have any questions or comments, feel free to contact me anytime at ktiedeman@dmhmrsas.state.va.us or Sawida Kamara at (804) 371-6981.

Sincerely,

Karyn Tiedeman
Needs Assessment Manager

APPENDIX H
FOLLOWUP REQUESTS FOR PHASE II PARTICIPATION

Date

«First_name» «Last_name»
«Program_Name»
«Agency»
«PO_Box»
«Address»
«City», «State» «ZipCode»

Dear «First_name» «Last_name»:

You are receiving this letter as a follow-up request for your participation in the Prevention Community Resource Assessment. As you may remember, the Department of Mental Health, Mental Retardation, and Substance Abuse Services received a contract from the Center of Substance Abuse Prevention to conduct a statewide prevention needs assessment. Your participation in the Community Resource Assessment is essential for the successful completion of the needs assessment. I am writing to remind you to please complete and return the survey previously mailed to you. If you do not intend on completing the survey, please contact us, so that we may remove your name from our mailing list. **As a reminder, please use a paperclip to bind the survey and Do Not Staple**.

We would like to thank you for taking time out of your busy schedule to assist us in this study. If you have any questions or comments, or would like another copy of the survey, feel free to contact me anytime at ktiedeman@charter.net or Sawida Kamara at skamara@dmhmrsas.state.va.us or at (804) 371-6981.

Sincerely,

Karyn Tiedeman
Needs Assessment Manager

Date
«First_name» «Last_name»
«Program_Name»
«Agency»
«PO_Box»
«Address»
«City», «State» «ZipCode»

Dear **«First_name» «Last_name»**:

I am writing to request your participation in a Community Resource Assessment that is being conducted by the Department of Mental Health, Mental Retardation, and Substance Abuse Services. Your participation is imperative for the successful completion of the study. As you may remember, the Community Resource Assessment is one component of a Statewide Prevention Needs Assessment for the Center of Substance Abuse Prevention.   The results of the Community Resource Assessment will be integrated with the results of two other studies, a Youth Survey and a Social Indicator Database, to form a comprehensive prevention needs assessment.

The purpose of the Needs Assessment is to provide local and state prevention planners with objective data that will assist in planning efforts. Results from the Community Youth Survey and the Social Indicator Database will identify salient risk factors, protective factors and prevalence information. Results from the Community Resource Assessment will identify available prevention resources in the Commonwealth of Virginia. Data from the three studies will be integrated to provide prevention planners with information regarding the match between identified need and available resources.   The main goal of the CSAP Prevention Needs Assessment is to provide prevention planners with current and accurate information that may be used to improve the match between service needs and available resources.

The results of the Youth Survey and Social Indicator Database are currently available. A final report of on the Youth Survey has been disseminated to the Community Service Boards prevention offices. In addition, the results of the Social Indicator Database are available on the department's website at http://www.dmhmrsas.state.va.us/Organ/CO/Offices/ORE/Prevention.asp

Currently, we are having difficulty completing the Community Resource Assessment due to lack of survey participation. You are receiving this letter to again request your participation. We cannot stress how important the information you provide will be for future prevention programming.   We also believe that your participation will be a great benefit to you and the prevention field. Resource assessments can assist prevention planners and providers to (1) examine the match between existing prevention policies and programs and identified prevention needs, (2) allocate prevention resources to close gaps in existing policies and programs, and (3) improve prevention accountability and track costs.

Your participation in the study involves completing the attached survey, designed to collect program process information. The survey will take approximately 30 minutes to complete. After completing the survey, please place it in the return envelope (enclosed) and return it by February 4, 2002. **Please use a paperclip to bind the survey and Do Not Staple**.

We would like to thank you for taking time out of your busy schedule to assist us in this study. If you have any questions or comments, feel free to contact me anytime at ktiedeman@charter.net or Sawida Kamara at (804) 371-6981.

Sincerely,

Karyn Tiedeman
Needs Assessment Manager